TSO KYLE PATIENT HISTORY

Patient Information:

Full Name:_____ Birth Date:_____ Today's Date:_____

If child, Guardian's name:_____

Contact Information: Please Circle Preferred Form of Communication: Call | Text | Email

Phone #:_____ Email Address:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Insurance Information: (Please provide both Medical and Vision ID Cards to the Front Desk)

Medical Insurance:_____ Vision:_____ Supplemental:_____

Name of Policy Holder:_____ Policy Holder Date of Birth:_____

Personal Medical History: (Circle any conditions you have or are being treated for)

None Diabetes Heart Disease High Blood Pressure High Cholesterol Cancer Premature Arthritis

Pregnancy Glaucoma Cataract Macular Degeneration Retinal Detachment Eye Turn Pterygium

Eye Surgeries: Lasik - RK – Cataract – Glaucoma – Retinal Tear/Hole – Retinal Detachment – Pterygium

Other Conditions or Eye Surgeries: _____

_____

Current Medications: _____

_____

Have you experienced Medication Allergies? NO | YES, list here:_____

Do you use tobacco products? NO | YES

Family Medical History: (Include only Parents, Grandparents and Siblings)

None Diabetes Heart Disease High Blood Pressure High Cholesterol Cancer Anemia Arthritis

Glaucoma Cataract Macular Degeneration Retinal Detachment Eye Turn Pterygium

Other: _____

Personal Social History:

Occupation:_____ Hobbies / Sports:_____

Average Daily Hours viewing Computer or Mobile Device:_____ hrs / day

Forms of Vision Correction: Prescription Glasses | OTC Glasses | Contact Lenses | None

Primary Care Physician:_____ or None