PREMIER VISION CARE

OPTOMETRY

Patient Information

First Name_____ Last Name_____ MI_____ Preferred Name_____
Date of Birth_____ Gender_____ Height_____ Weight_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Cell Phone_____ Email_____
Occupation_____ Employer_____ Marital Status_____
Emergency Contact Name_____ Relation_____ Phone_____
Primary Vision Insurance_____ Name of Insured_____ Insurance Number or Last 4 digits of SSN_____

How did you hear about our office?_____

Ocular History

Reason for visit_____ Date of Last Visual Exam_____ Do you wear glasses No Yes
Do you wear contact lenses No Yes Type of contact lenses_____ Interested in contact lenses No Yes
Glaucoma No Yes Macular Degeneration No Yes Surgery_____
Cataracts No Yes Diabetic Retinopathy No Yes Other_____

Medical History

Medication(s) Name_____ Reason_____
Medication(s) Name_____ Reason_____
Medication(s) Name_____ Reason_____

Allergies (Drug, Environmental) Name_____ Reaction_____

Immunologic	No	Yes	_____	(Rheumatoid Arthritis, Lupus, Other)
Cardiovascular	No	Yes	_____	(Hypertension, Cholesterol, Stroke, Other)
Genitourinary	No	Yes	_____	(STD Viral Herpetic Chlamydia, Other)
Endocrine	No	Yes	_____	(Type I DM, Type II DM, Thyroid Dysfunction)
Musculoskeletal	No	Yes	_____	(Fibromyalgia, Arthritis, Other)
Neurological	No	Yes	_____	(Multiple Sclerosis, Epilepsy, Alzheimer's, Other)
Hematologic Lymphatic	No	Yes	_____	(Anemia, Blood Disorder, Leukemia, Other)
Psychiatric	No	Yes	_____	(Depression, Anxiety, ADHD, Other)
Constitutional	No	Yes	_____	(Weight Loss, Fever, Fatigue, Trauma, Other)
Ear, Nose, Mouth & Throat	No	Yes	_____	(Ear Ache, Runny Nose, Sore Throat, Other)
Gastrointestinal	No	Yes	_____	(Cohn's, Colitis, Ulcer, Digestive, Other)
Respiratory	No	Yes	_____	(Asthma, Bronchitis, Emphysema, Other)
Integumentary	No	Yes	_____	(Eczema, Rosacea, Psoriasis, Other)

Family History

Macular Degeneration	No	Yes	Relation_____	Glaucoma	No	Yes	Relation_____
Diabetes Mellitus	No	Yes	Relation_____	Cataracts	No	Yes	Relation_____
Hypertension	No	Yes	Relation_____	Other	No	Yes	Relation_____

Social History

Alcohol Use No Yes Frequency_____ Smoking No Yes Frequency_____
Computer Use No Yes Frequency_____ Hobbies/Lifestyle_____