Plymouth Family Optometry LLC
212 S. Meadow Rd, Unit 5C, Plymouth, MA 02360
Dr. Ryan Racette, Optometrist

New Patient Intake Form

Last name:_____First name :_____MI_____

Address:_____

Telephone 1: (_____)_____Type: Home / Work / Cell Email:_____

Telephone 2: (_____)_____ Type: Home/Work/Cell

Date of Birth:_____Age:_____Sex: M F

Emergency Contact _____ Phone (_____)_____ Relationship _____

Reason for Today's Visit _____

Are you experiencing any of the following? (please circle)

Blurry Vision Burning Double Vision Dryness Flash of Light Floaters/spots in vision Grittiness

Headaches Infection Itchiness Night vision difficulty Eye pain Tearing

Have you been diagnosed with the following?

None Glaucoma

Cataracts Iritis/uveitis

Corneal abrasion Macular degeneration

Dry Eye Retinal defect/hole/tear

Eye turn / lazy eye Retinal detachment

Other eye diseases

Has anyone in your family been diagnosed with the following? If so, who?

None Retinal detachment

Glaucoma Macular degeneration Other eye diseases? _____

Do you have vision insurance? Yes No If yes, which one? _____ Member ID: _____

Do you medical insurance? Yes No

Medical Insurance: _____ PPO/HMO/IPA/Other: _____

Member ID: _____

Group: _____

Policy Holder's Name if Different _____

Policy Holder DOB: ____/_____/_____ SSN: _____

Relationship to Patient: _____

Visual Needs

Hours of computer usage per day: _____

Hours of outdoor activity per day: _____

Hobbies: _____

Sports: _____

How many minutes/hours do you read before you experience fatigue?: _____

Circle if you have: eyestrain, neck strain, headaches

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

Would you benefit from thinner, lighter lenses? Yes No

Do you have sensitivity to bright lights? Yes No

Do you have a pair of sunglasses? Yes No

Do you have computer vision problems? Yes No

Do you have back-up glasses? Yes No

Do you have problems with glare/reflections? Yes No

Do you spend a lot time outdoors? Yes No

Do you have computer glasses? Yes No

How did you find Plymouth Family Optometry? _____

Medical History

Date of last medical examination _____/_____/_____ Name of Primary Care Provider _____

Name of other specialists w/ specialty _____

_____

Current Medications and Dose (include eye drops, over the counter, supplements, aspirin, and oral contraceptives)

_____

_____

_____

_____

Please list all allergies to medications or foods, and seasonal allergies and specific reaction

_____

_____

_____

_____

_____

List any prior eye surgeries and dates if known (include LASIK, other laser procedures, injections)

_____

_____

List all major injuries, surgeries (other than eye), and hospitalizations you have had

_____

_____

Are you pregnant or nursing? Yes No

Do you smoke cigarettes? Yes No If so, how often? _____ Former smoker? Yes No

Do you drink alcohol? Yes No If so, how often?

Do you use recreational drugs? Yes No

Have you ever been exposed to or infected with? HIV Hepatitis Gonorrhea Syphilis Other _____

Occupation _____

Do you currently have or have you ever had problems in the following areas?

Diabetes? Yes No If so, what type? _____ How long ago diagnosed? _____ Last A1c reading? _____

High blood pressure? Yes No How long ago diagnosed? _____ Last BP reading? _____

Cardiovascular problems (high cholesterol, heart disease, arrhythmia, cancer) etc? Yes No

Endocrine problems (high/low thyroid, cancer, etc) ? Yes No

Neurological problems (stroke, numbness, weakness, headaches, paralysis, seizures, cancer, etc)? Yes No

Ear, nose, mouth/throat problems (hearing loss, sinus problems, sore throat, cancer, etc)? Yes No

Gastrointestinal/liver problems (heartburn, abdominal pain, cirrhosis, hepatitis, cancer, etc)? Yes No

Genitourinary problems (discharge, pain, blood in urine, cancer, etc)? Yes No

Blood or lymph problems (anemia, leukemia, HIV/AIDS, cancer, etc)? Yes No

Skin problems (rashes, excessive dryness, non-healing sores, cancer, etc)? Yes No

Musculoskeletal problems (muscle aches, joint pain, swollen joints, arthritis, cancer, etc)? Yes No

Psychiatric problems (depression, anxiety, etc.) ? Yes No

Respiratory problems (wheezing, cough, asthma, tuberculosis, bronchitis, cancer, etc.)? Yes No

Autoimmune diseases (Lupus, Crohn's disease, rheumatoid arthritis)? Yes No

Recent fever for more than 10 days, unexpected weight loss or gain, fatigue? Yes No

If answered yes to any of the questions above, please specify diagnosis. Also list conditions that were not asked about above

_____

_____

_____

_____

_____

Please note any family history (parents, grandparents, siblings, children, living or deceased)

Heart disease Yes No Who? _____

Lupus Yes No Who? _____

Arthritis Yes No Who? _____

Diabetes Yes No Who? _____

Kidney Disease Yes No Who? _____

Cancer Yes No Who? _____

High blood pressure Yes No Who? _____

Thyroid disease Yes No Who? _____

Other conditions

_____

_____

Signature of Patient or Legal Guardian _____Date _____/_____/_____