PATIENT INFORMATION

| Last NameFirst | | MI | Male Female Birth Date |
|-----------------------------------------------------|-------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Address | City_ | | State Zip |
| Telephone, Home () | Work (|) | Extension |
| imployer's Name | | | |
| Occupation | ngest me I boale | Referred By | agels subbas fleeyers solves iversition militages to restrict |
| Social Security No | | | ervices not coyeted by insurance carrier. |
| Health and Vision Insurances | | | 91005 |
| | PATIENT | HISTORY | |
| What is your primary reason for today's exam? | CPS | 6537 | |
| Age of present glassesL | ast eye exam date | e /_/_ | From Dr. |
| | | | YES", please provide information. |
| Do you currently have any prob | | | |
| | YES | NO | EXPLANATION OF PROBLEM |
| Eyes (Glaucoma, cataract, retinal disease, etc. | | | TAGRIT JROVE SH |
| Loss of vision | | | THE SHE INTECTION, EDITORS COURS, ON STOLEN. (EC.) |
| Blurred vision | | | (NOTONASCAULAN (Hear, Teases, etc.) |
| Fluctuating vision | | | SPRATORO (Author, cophycems, etc.) |
| Distorted vision (halos) | | | STROINTESTINAL |
| Loss of side vision | | | maca electre, interconal discrete, inc.) |
| Double vision | | | METAL KEDREY, BLADDEK |
| Dryness | | | Jacobs, BOMES, PARTS (Adhess, ed.) |
| Mucous discharge | | | [18 [Acrost water, skip capeer, erc.] |
| Redness | | | (DRC), CARCINE eligible extensis, etc.) |
| Sandy or gritty feeling | | | (Ciff(A) 101C (Anxiety, depression, incomin) |
| Itching | | | OCCAINE (Disberes, hypothytoid; etc.) |
| Burning | | | CODA WIFT (Cholementeres, enema, etc.) |
| Foreign body sensation | | | DEDOLOPE MANUSCORE |
| Excess tearing/watering | | | v fever Jupos, Sjogrens, etc.) |
| Clare/light consistivity | | | |
| | | | 2000 Province and 20 to |
| Eye pain or soreness | | | 3000 |
| Infection of eye lid (blepharitis, stye) | | | |
| Tired eyes | | | \$1000000000000000000000000000000000000 |
| Crossed eyes, lazy eye | | | |
| Drooping eyelid | | | |
| Have your eyes ever been dilated? No | Yes When | | Legisci control |
| Are you taking any medication? No | | | |
| | | | I meanth wan |
| Are you allergic to any medication? No | Yes Pleas | e list | 1 |
| Have you ever had an eye infection, disease, injury | or surgery? | No Yes | Please list |
| 2 1 11 11 11 11 11 N | V | | |
| Do you have trouble with night vision? No | | | |
| Oo you work with a computer? No Yes | | | VACTURE LA |
| What sports and hobbies do you enjoy? | | No. V | and the first to the first to the second sec |
| Would you like information concerning laser vision | | | |
| No of children | CONTACT L | | al status (married, diverced, single, andosred) Y |
| lave you ever worn contact lenses? | No | Yes | |
| Do you now wear contact lenses? | No | Yes | addeds alcoholt O. YES O NO 16 |
| Are you interested in new contact lenses? | | 100 | |
| What lens care system do you use? | | | rand used |
| lave you ever had a reaction to eye drops or any le | | | |
| How old are your contact lenses? R | | | |
| Type of contact lenses worn Hard Gas Peri | m Soft I | Extended Wear | Astigmatism Bifocal Disposable |

LIFETIME INSURANCE AUTHORIZATION

Please have insurance card(s) available for photocopying

Insurance Authorization and Assigment

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances/or amounts for services not covered by insurance carrier.

| Signature | China and | Date | | | | | |
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| | | YES | NO | EXPLA | NATION OF PRO | OBLEM | |
| GENERAL/CONSTITU | UTIONAL | | | | | | |
| Fever | tradition to the accompany of the ARE ARE ARE | | Constitution of the Consti | and the second s | | State of the second second | |
| Weight loss | malai farvoig seese; | Call 2 . lessif | in province on | in anadory via sve. | S Plinterio GOV OC | | |
| Other | EXPLANATION C | | си Г | 37 | | | |
| EARS, NOSE, THROA | |) | | sesse, etc. | | | |
| CARDIOVASCULAR | (Heart, vessels, etc.) | | | | | mary from the | |
| RESPIRATORY (Asthn | na, emphysema, etc.) | | | | | | |
| GASTROINTESTINA (Stomach ulcers, intestina | | | | | (sole: |) invited baseous f | |
| GENITAL, KIDNEY, B | LADDER | | | | | record or while and A | |
| MUSCLES, BONES, JO | OINTS (Arthritis, etc.) | | | | | | |
| SKIN (Acne, warts, skin | cancer, etc.) | | | | | grand of a new acida. | |
| NEUROLOGICAL (M | ultiple sclerosis, etc.) | | | | | | |
| PSYCHIATRIC (Anxie | ty, depression, insomnia) | | | | 5.731 | on verse an absolute | |
| ENDOCRINE (Diabetes | , hypothyroid, etc.) | | | | | geritali | |
| BLOOD/LYMPH (Chole | esterolemia, anemia, etc.) | | | | | gairreil | |
| ALLERGIC/IMMUNO | LOGIC | | | | | keesign body sensi | |
| (Hay fever, lupus, Sjogrens | s, etc.) | | | | | | |
| FAMILY HISTORY | | | | m= mother f = fa | ther s = sibling | gp = grandparent | |
| DISEASE | | YES | NO | RELATI | IONSHIP TO PA | TIENT | |
| Blindness | | | | | | | |
| Glaucoma | | organisti territori estatul decem | | | | | |
| Arthritis | | | | | A Section of the sect | | |
| Cancer | | | | | | carata Starbasara | |
| Diabetes | | | ned | 9 asy old | Liberally need | fave your eyes ever | |
| Heart disease or high bl | ood pressure | | this same | A saY nM | Leougabae | tee you taking say i | |
| Kidney disease | | | | | | | |
| Lupus | | | 101 1000011 | BE OPT money | Linculabilities yes | e od Słycelle woy esi | |
| Stroke | | | 100 | | | | |
| Thyroid Disease | eroscono estratagamente como 2002 Color | M2.3 63.1 | | pilitico ira Autolias Yolottadi | ss ministrance of a su | E DAM ENTREME STREET | |
| Other | | | | - N | | | |
| COCKAN ANGMORY | | | | | | | |
| SOCIAL HISTORY | | | | | | | |
| Education (high school, v | ocational school, colleg | ge degree): | _0//1ee | <u> Dantan nords terti u</u> | Carte and a facilities | | |
| Marital status (married, di | vorced, single, widowed | d)(b) | | TWOO | No. of childre | n | |
| Do you drive? | ☐ YES ☐ NO |) | | | | | |
| Do you drink alcohol? | ☐ YES ☐ NO | If YES: | Occasional | 1 per day | 2-3 per day | 4+ per day | |
| Do you smoke? | ☐ YES ☐ NO | If YES: | Occasional | 1/2 pack per day | 1 pack per day | 1+ pack per day | |
| Have you ever had a blood | Commence of the second | | , inomine poi | riarlo cost yas ro agro | di sya na cina che di | s bud on a usu sual | |
| Physician's Signature: | | d boni ²⁸ | densell i - iki | | | | |