PATIENT INFORMATION

Last Name _____ First _____ MI ___ Male ___Female ___Birth Date_____
Address _____City _____State _____Zip _____
Telephone, Home ( )_____ Work ( ) _____ Extension_____
Employer's Name _____
Occupation _____ Referred By _____
Social Security No. _____-_____-_____ Your Physician _____
Health and Vision Insurances _____

PATIENT HISTORY

What is your primary reason for today's exam? _____
_____
Age of present glasses _____ Last eye exam date ___/___/____ From Dr. _____

Do you *currently* have any problems in the following areas? If "YES", please provide information.

	YES	NO	EXPLANATION OF PROBLEM
Eyes (Glaucoma, cataract, retinal disease, etc.			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

Have your eyes ever been dilated? ___ No ___ Yes When _____
Are you taking any medication? ___ No ___ Yes Please list _____
_____
Are you allergic to any medication? ___ No ___ Yes Please list_____
_____
Have you ever had an eye infection, disease, injury or surgery? ___ No ___ Yes Please list_____
_____
Do you have trouble with night vision? ___ No ___ Yes
Do you work with a computer? ___ No ___ Yes How many hours per day?_____
What sports and hobbies do you enjoy? _____
Would you like information concerning laser vision correction? ___ No ___ Yes

CONTACT LENS HISTORY

Have you ever worn contact lenses? ___ No ___ Yes
Do you now wear contact lenses? ___ No ___ Yes
Are you interested in new contact lenses? ___ No ___ Yes
What lens care system do you use? ___ Heat ___ Chemical, Brand used _____
Have you ever had a reaction to eye drops or any lens cleaning solution? ___ No ___ Yes, Describe_____
How old are your contact lenses? R_____ L _____ Fitted by _____
Type of contact lenses worn ___ Hard ___ Gas Perm. ___ Soft ___ 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 _____ **Date**_____

	YES	NO	EXPLANATION OF PROBLEM
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

m= mother f = father s = sibling gp = grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

SOCIAL HISTORY

Education (high school, vocational school, college degree): _____

Marital status (married, divorced, single, widowed)_____ No. of children_____

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 transfusion? ❒ YES ❒ NO

Physician's Signature: _____