HARBOR EYE ASSOCIATES

David J. Dexter OD
James Forde OD

Lori A. Youngman OD
Laura Davis OD

Date: _____ / _____ / _____

Name:_____ SS#_____

Address:_____ City: _____ Zip: _____

Email: _____

Cell Ph.: _____ Work Ph.: _____ House Ph.: _____

Birthdate: _____ / _____ / _____ Age: _____ Sex: _____

School: _____ Grade: _____

Employer: _____

Account Responsibility: _____ Birthdate: ____ / ____ / _____

Address: _____ Phone: _____

Employer: _____ Phone: _____

Insurance: _____ Policy # _____

2nd Insurance: _____ Policy # _____

Vision Insurance: _____ Policy # _____

Primary Medical Physician: _____

Last Medical Exam: _____

Last Vision Exam: _____

Who in your family have we examined? _____

How did you hear about us? _____

(Continued on back)

Reason for this exam: _____

Do you wear or have you worn eyeglasses or contacts? _____

Are you interested in contacts today? _____

Eye History:

Glare/Light Sensitivity	Yes ____ No ____				
Blurred Vision Distance	Yes ____ No ____				
Blurred Vision Near	Yes ____ No ____				
Headaches	Yes ____ No ____	Discharge	Yes ____ No ____		
Burning	Yes ____ No ____	Redness	Yes ____ No ____		
Dryness	Yes ____ No ____	Double Vision	Yes ____ No ____		
Itching	Yes ____ No ____	Floaters	Yes ____ No ____		
Flashes of light	Yes ____ No ____	Eye Pain	Yes ____ No ____		

Do you have any medical problems?

____ Cardiovascular (High blood pressure, etc.)
____ Respiratory (Asthma, COPD, etc.)
____ Endocrine (Diabetes, thyroid, etc.)
____ Muscles, bones joints (arthritis, etc.)
____ Gastrointestinal
____ Skin
____ Allergic/Immunologic
____ Neurologic
____ Cancer
____ Other

Do you smoke? Yes ____ No ____
Do you drink alcohol? Yes ____ No ____
Do you use recreational drugs? Yes ____ No ____

Current Medications

_____ _____ _____
_____ _____ _____
_____ _____ _____

Past Surgery: _____

Allergies to Medications: _____

Family History or eye problems? _____

Family History of Medical problems (High Blood Pres., Diabetes, cancer, etc.)

_____

_____