CONTACT INFORMATION

Date: _____

Patient Information

Name: _____ Nickname: _____ M S W D

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Birthdate: _____ Age: _____ Sex: M F

Job Title: _____ Employer: _____ SSN: _____

Contact Preference
- □ Telephone
- □ Mail
- □ E-mail

Race
- □ White
- □ Asian
- □ Hawaiian

- □ Hispanic
- □ American Indian
- □ Alaskan Native
- □ African American

Preferred Language
- □ English
- □ Spanish
- □ Other:

Other family members seen in our office: _____

Responsible Party Information

Name: _____ Relationship to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Driver's License: _____

Email: _____ Birthdate: _____ Age: _____ Sex: M F

Job Title: _____ Employer: _____ SSN: _____

Insurance Information

Vision Insurance: _____ Insurance ID: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Address: _____

Phone: _____ Birthdate: _____ Employer: _____

Secondary Vision Insurance: _____ Insurance ID: _____

Policy Holder: _____ Relationship to Patient: _____

Medical Insurance: _____ Insurance ID: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder Address: _____

Phone: _____ Birthdate: _____ Employer: _____

Secondary Medical Insurance: _____ Insurance ID: _____

Policy Holder: _____ Relationship to Patient: _____

MEDICAL HISTORY

Date: _____

Patient Name: _____ Name of Medical Doctor: _____

List Current Medications: _____

_____

_____

_____

Drug Allergies/Sensitivities: _____

_____

REVIEW OF SYSTEMS Do you have, or have you ever had problems in the following areas:

ALLERGY
- Seasonal Allergies/Hay Fever Y N
- Food Allergies Y N

CARDIOVASCULAR
- Heart Problem Y N
- High Blood Pressure Y N
- High Cholesterol Y N
- Other: _____

CONSTITUTIONAL
- Weight Loss/Gain Y N
- Motion Sickness Y N

PSYCHIATRIC
- Dementia/Alzheimer's Y N
- Anxiety/Depression Y N

HEMATOLOGIC/LYMPHATIC
- Anemia Y N
- Bleeding Problems Y N

ENDOCRINE
- Diabetes Y N
- Thyroid Disorder Y N
- Crohn's Disease Y N

MUSCULOSKELETAL
- Rheumatoid Arthritis Y N
- Osteoporosis Y N
- Down's Syndrome Y N

GASTROINTESTINAL
- Ulcers Y N
- Hepatic Disease Y N
- Other: _____

IMMUNOLOGIC
- Chicken Pox/Shingles Y N
- HIV/AIDS Y N
- Lyme Disease Y N
- Other: _____

NEUROLOGICAL
- Headaches Y N
- Migraines Y N
- Seizures Y N

INTEGUMENTARY
- Lupus Y N
- Psoriasis Y N
- Rosacea Y N
- Other: _____

GENITOURINARY
- Kidney Stones Y N
- Other: _____

RESPIRATORY
- Asthma Y N
- Chronic Bronchitis Y N
- Emphysema Y N

EYE HISTORY Do you have, or have you ever had problems in the following areas:

Cataracts	Y N	Mucous Discharge	Y N	Eye Pain/Soreness	Y N
Macular Degeneration	Y N	Redness	Y N	Chronic Eye Infections	Y N
Glaucoma	Y N	Sandy or Gritty Feeling	Y N	Sties/Infection on Lids	Y N
Crossed/Lazy Eyes	Y N	Itching	Y N	Flashes/Floaters	Y N
Loss of Vision	Y N	Burning	Y N	Eye Surgery:	
Blurred Vision	Y N	Excess Watering	Y N		
Double Vision	Y N	Glare	Y N		
Dryness	Y N	Light Sensitivity	Y N		

ARE YOU CURRENTLY…

FAMILY HISTORY Please note any family history in the following areas:

Pregnant or Nursing? Y N

Wearing Glasses? Y N

Wearing Contact Lenses? Y N

Type: _____

Do you use Tobacco? Y N

Do you drink Alcohol? Y N

Use other Substances? Y N

Date of last eye exam: _____

Glaucoma:

Macular Degeneration: _____

Cancer:

Diabetes:

High Blood Pressure:

Lupus:

Thyroid Disease:

Other: