## Welcome To Our Office

		*	Date of	appointment:
Patient Name: (First)	(M.I.)	(Last)		S.S.#
Address:		City, 9	State, Zip:	
Telephone: (H) (W)		_ Cell		E-mail:
D.O.B/ Age:	S	ex: o Male o	Female	
Occupation:	Em	ployer:		
How Did You Hear About Our Office? (Ple	ase be specific): _			
Date of Last Eye Examapproximate if use Vision Insurance Plan:	nsure			
Person responsible for account:		Patien	t Signature:	
REASON FOR TODAY'S VISIT:			Par	ent or Guardian if under 18 years of age
MEDICAL HISTORY:				
Do you have any allergies to medications?	o No o Yes	If ves. please l	ist:	
List all medications and conditions for whi	en you are taking	tnese meas:		
OCULAR HISTORY:				11144494
Have you ever had an eye injury, eye opera	tion, or serious ey	re infection? o	No o Yes	If yes, please explain
			****	
List any of the following that you have had	: crossed eyes, laz	y eye, drooping ey	elid, glaucoma,	cataracts, retinal disease or
detachment?				
Are you pregnant and/or nursing?	o No o Yes	If yes, what is/wa	s your delivery	date?
Have you ever worn glasses?	o No o Yes	If yes, how old is	your present pa	ir of lenses?
Have you ever worn contact lenses?	o No o Yes	If yes, how old is	your present pa	ir?
Type of contact lenses: o Rigid o Soft	o Extended Wear	r o Disposable	o Other A	re they comfortable? o No o Yes
If disposable, how often do you dispose of	them? o 1-2 V	Weeks o 1 Mont	h o 2 Month	o 3 Month o Other
FAMILY HISTORY: Please no	te any family histor	y (parents, grandpar	ents, etc.) for the f	ollowing conditions:
DISEASE/CONDITION		NO	YES	RELATIONSHIP TO YOU
Cataract		0	0	
Glaucoma		0	0	
Macular Degeneration		0	0	
Retinal Detachment		0	0	
Diabetes			0	
Cancer			0	
Heart Disease			0	
High Blood Pressure		0	0	

0

Do you use tobacco products? o No o Yes Do you drink alcohol? o No o Yes Do you use illegal drugs? o No o Yes									
Do you currently have any problems in the following area?									
YSTEM	NO	YES		NO	YES				
ONSTITUTIONAL			EAR, NOSE, MOUTH, THROAT						
Fever, Weight Loss/Gain	0	0	Allergies/Hay Fever	0	0				
NTEGUMENTARY (Skin)	0	0	Sinus Congestion	o	o				
EUROLOGICAL			Runny Nose	0	o				
Headaches	0	0	Post-Nasal Drip	0	0				
Migraines	0	0	Chronic Cough	0	0				
Seizures	0	0	Dry Throat/Mouth	0	0				
YES			RESPIRATORY						
Loss of Vision	O	0	Asthma	0	0				
Blurred Vision	0	0	Chronic Bronchitis	o	O				
Distorted Vision/Halos	0	0	Emphysema	O	0				
Loss of Side Vision	0	0	VASCULAR/CARDIOVASCULAR						
Double Vision	0	0	Diabetes	0	0				
Dryness	0	0	Heart Pain	0	0				
Mucous Discharge	0	0	High Blood Pressure	0	0				
Redness	0	0	Vascular Disease	0	0				
Sandy or Gritty Feeling	0	0	GASTOINTESTINAL Diarrhea						
Itching	0	0		0	0				
Burning Foreign Body Sensation	0	0	Constipation GENITOURINARY	0	U				
Excess Tearing/Watering	0	0	Genitals/Kidneys/Bladder	0	0				
Glare/Light Sensitivity	0	0	BONES/JOINTS/MUSCLES	Ü	U				
Eye Pain or Soreness	0	0	Rheumatoid Arthritis	0	0				
Chronic Infection of Eye or Lid		0	Muscle Pain	0	0				
Sties or Chalazion	0	0	Joint Pain	0	0				
Flashes/Floaters in Vision	0	0	LYMPHATIC						
Tired Eyes	0	0	Anemia	0	o				
NDOCRINE			<b>Bleeding Problems</b>	0	0				
Thyroid/Other Glands	0	0	ALLERGIC/IMMUNOLOGIC	О	o				
			PSYCHIATRIC	0	o				

Doctor's Signature

Date