Welcome to Our Office

TODAY'S DATE

PATIENT INFORMATION

PATIENT NAME | SOC. SEC. # | DRIVER'S LIC. # | BIRTHDATE

ADDRESS | CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE | CELL PHONE | OCCUPATION | EMPLOYER

NAME OF PARENT OR SPOUSE | GRADE IF STUDENT | DO YOU USE A COMPUTER ?

_____ NO _____ YES; HOW MUCH ?

HAVE WE SEEN OTHER MEMBERS OF YOUR FAMILY? ___ YES ___ NO IF YES, WHOM ?

E-MAIL ADDRESS

MEDICAL HISTORY

NAME OF FAMILY PHYSICIAN & CITY | WHEN WAS YOUR LAST MEDICAL EXAM?

LIST ANY MEDICAL CONDITIONS YOU ARE BEING TREATED FOR | LIST ANY MEDICATION ALLERGIES

LIST MEDICATIONS YOU ARE TAKING (INCLUDE HORMONES /BIRTH CONTROL & NON-PRESCRIPTION MEDS)

WHICH PHARMACY DO YOU PREFER?

NAME OF LAST EYE DOCTOR & CITY | WHEN WAS YOUR LAST EYE EXAM?

DO YOU SMOKE ? Yes / No HOW MUCH ? | DO YOU USE ALCOHOL ? YES / NO | DO YOU USE RECREATIONIAL DRUGS ? YES / NO

CIRCLE ANY MEDICAL CONDITIONS THAT APPLY TO YOU :

DIABETES ALLERGIES ASTHMA HEART DISEASE VASCULAR DISEASE HIV HEADACHES
CANCER LUNG DISEASE ARTHRITIS HIGH BLOOD PRESSURE HEAD TRAUMA SEIZURES HEPATITIS
OTHER ; PLEASE LIST _____

CIRCLE ANY EYE CONDITIONS THAT APPLY TO YOU :

EYE DISEASE EYE SURGERY GLAUCOMA CATARACTS DRY EYE TURNED EYE LAZY EYE VISION THERAPY
GLASSES EYE PAIN LIGHT SENSITIVE
OTHER: PLEASE LIST_____

CIRCLE CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS

CATARACTS GLAUCOMA DIABETES HEART DISEASE HIGH BLOOD PRESSURE RETINAL DEGENERATION
OTHER EYE DISEASES _____
OTHER INHERITED CONDITIONS _____

CONTACT LENS HISTORY

_____ NEVER WORN CONTACTS _____ NOT INTERESTED IN CONTACTS _____ CURRENTLY WEARING CONTACT LENS

_____ WOULD LIKE TO KNOW MY CONTACT LENS OPTIONS

ACTIVITIES / SPORTS / HOBBIES

I PARTICIPATE IN : PLEASE CIRCLE

CONTACT SPORTS FISHING SHOOTING / HUNTING WATER / SNOW SKIING GOLF SEWING / NEDDLECRAFTS
RACQUETBALL COMPUTER

DILATION OF THE PUPILS ALLOWS THE DOCTOR TO FULLY EXAMINE THE INTERIOR OF YOUR EYE TO CHECK FOR DISEASE. PLEASE TELL US IF YOU HAVE HAD ANY COMPLICATIONS TO EYE DROPS. WE ALWAYS USE THE MOST APPROPRIATE MEDICATIONS TO MINIMIZE COMPLICATIONS.

Who can we give thanks for your referral ?

I PREFER TO HAVE MY EYES DILATED ____ TODAY ___ ON RETURN VISIT
I REFUSE TO ALLOW MY EYES TO BE DILATED____ WHY? _____

IF YOU HAVE ANY HEALTH INSURANCE THAT OUR OFFICE WILL BE REQUIRED TO FILE, PLEASE PRESENT THAT INFORMATION TO FRONT DESK. THANKS.