

WELCOME TO OUR OFFICE

The following information will aid your doctor in providing the most complete care possible. Please answer the questions to the best of your knowledge.

PATIENT INFORMATION

Name (Mr. • Mrs. • Ms. • Dr. • Fr. • Sr.) _____ Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Phone (H) _____ Phone (W) _____ Phone (C) _____
Social Security # _____ Do you use a computer? _____ Email address: _____
Occupation _____ If enrolled in school, your grade level _____ Employer /School _____
How did you find out about our office? _____

PAYMENT INFORMATION

Please circle the method of payment for today's professional services: Cash Check VISA/MC DISCOVER
Does your health insurance cover all or part of your bill: Yes No If Yes, Name of Insurance Company _____
Party responsible for payment: Self Other Name (if other) _____ SS# (if other) _____
Address _____ Phone _____

OCULAR HISTORY

When was your last complete eye exam? _____ Are you presently having difficulties with your vision? Yes No
If yes, please briefly describe _____
Do you ever experience any of the following ocular or vision related symptoms (please check all that apply):
 Blur at Distance Redness of Eyes Itching of Eyes Headaches Light Sensitivity Fluctuating Vision
 Blur at Near Burning of Eyes Excessive Tearing Double Vision Spots or Floaters Trouble with night vision
To get a better sense of how you use your eyes, are there any hobbies, sports, or other recreational activities you participate in on a regular basis?

Have you ever had a problem with your eyes requiring treatment other than glasses (i.e., drops, patching, surgery, eye exercises, etc.) _____

MEDICAL HISTORY

When was your last complete physical? _____ What is your doctor's name? _____
Do you have any reason to believe you have any of the following problems? (please check all that apply)
 High blood pressure High cholesterol Asthma Food/drug allergies Cataracts Head injury
 Diabetes Thyroid disorder Skin disorder Seasonal allergies Glaucoma Do you smoke? Y / N
Do you have any other health problems? _____
Does anyone in your family have any health problems? High blood pressure Diabetes Sickle Cell Other _____
Has anyone in your family ever been diagnosed with an eye disease? (please list) _____
Are you currently taking any medications? (Please list any including birth control pills or vitamin supplements) _____
Are you currently wearing eyeglasses? _____ Are you satisfied with the quality of the vision through these glasses? _____
If you are unsatisfied with your glasses, what is it you are unsatisfied with? _____ Do you own prescription sunglasses? _____
Are you currently using contact lenses? Yes No Soft Firm Disposable Colored Are you satisfied with the vision through your lenses? _____
If you are having problems with your lenses, what are they? _____
What solutions are you using? _____ How often do you change your lenses? _____ How many hours do you wear your lenses? _____
If no contacts are worn, are you interested in wearing contacts? Yes No If yes, are you interested in: Soft Firm Disposable Colored Bifocal

Thank You