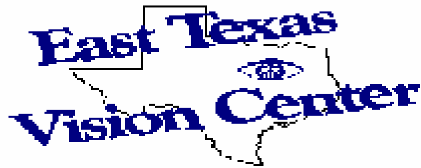

Personal Information

Last Name: ____________________ First Name: _________________ MI: __

Address: ____

City: ____________________ State: _______________ Zip Code: _________

Home Phone: ________________________ Work Phone: ________________________

Cell Phone:__________________________ Have you been here before? _____________

Date of Birth: _____ / _____ / _____ Social Security #: ______ - ____ - ______

Employer / School: ___________________ Occupation / Grade: ___________________

Insurance

Do you have Vision Insurance? □ Yes □ No If yes, which provider? ________________

Insurance Member ID #: ______________ Group Number: ______________________

Name of Primary holder and DOB: ____

Do you have Medical Insurance? □ Yes □ No If yes, which provider? ________________

Insurance Member ID #: ______________ Group Number: ______________________

Medications & Allergies

Please list all medications you are currently taking (including birth control, vitamins, and herbs): ____

____

Are you allergic to any medications? □ Yes □ No If yes, what? ___________________

Do you have general/seasonal allergies? □ Yes □ No If yes, what? ___________________

Do you use tobacco products? □ Yes □ No Do you use alcohol? □Yes □No

Medical Review

What is the reason for today's exam? ____________________

When was your last eye exam? ____________________

What do you primarily use to correct your vision? □ Glasses □ Contacts

Do you wear glasses? □Yes □No If yes, for... □ Reading □ Computer □ Full Time

Do you wear contacts? □ Yes □ No If yes, what type? ____________________

Do you take eye drops? □ Yes □ No If yes, what type? ____________________

Would you like to try contacts? □ Yes □ No

Would you like laser vision correction? □ Yes □ No

Please check any symptoms you may be experiencing:

□ Blurred Vision □ Glare □ Tearing/Watering □ Light Sensitivity
□ Discharge □ Red Eyes □ Eye Injury □ Eyestrain
□ Eye Pain □ Distorted Vision □ Double Vision □ Loss of Vision
□ Dryness □ Burning □ Irritation □ Sties/Chalazion
□ Eyestrain (PC) □ Fluctuating Vision □ Loss of Side Vision □ Flashes of Light
□ Floating object sensation □ Difficulty driving at night □ chronic infection of eye/lid
□ Sandy/Gritty □ Floating Spots □ Itching □ Other________________

Medical Review of family history

Please indicate any condition that applies to you or a family member:

	Who?		Who?
Diabetes	____________	Retinal Detachment	____________
High Blood Pressure	____________	Eye Surgery	____________
Cancer	____________	Lazy Eye	____________
Heart Problems	____________	Double Vision	____________
Respiratory Problems	____________	Blindness	____________
Thyroid Problems	____________	Loss of Vision	____________
Headaches	____________	Glaucoma	____________
Stroke	____________	Macular Degeneration	____________
Head/Eye injury	____________	Cataracts	____________

How did you find our office?

□ Yellow Pages □ Location □ Radio □ Family □ Doctor
□ Insurance Plan □ Mail Out □ Television □ Newspaper