

Welcome to our office! We want to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (PLEASE PRINT)

PATIENT INFORMATION

Last Name _____ Suffix _____ First Name _____ Middle Initial _____
 Gender: _____ Title (circle one) Mr. Mrs. Ms. Miss Master Dr. Rev.
 Name you prefer to be called (if different than first name) _____
 Mailing Address _____
 City _____ State _____ Zip _____
 Social Security # _____ Date of Birth ____/____/____
 Employer: _____ Occupation: _____
 Home # (____) _____ Cell # (____) _____ Work # (____) _____
 Email _____
 Whom may we thank for referring you to us? _____
 Emergency Contact _____ Phone _____

RESPONSIBLE PARTY (If different than the patient, please complete the following.)

Last Name _____ Suffix _____ First Name _____ Middle Initial _____
 Title (circle one) Mr. Mrs. Ms. Miss Master Dr. Rev.
 Mailing Address _____
 City _____ State _____ Zip _____
 Home # (____) _____ Work # (____) _____
 Email _____ Social Security # _____

INSURANCE INFORMATION

Insurance Company: _____ Primary Policy Holder: _____
 Patient's Relationship to Policy Holder: Self Spouse Child

I authorize any holder of medical or other information about me to release to the S/S administration or any other carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits either to myself or to the party who accepts assignment below. I understand that I am responsible for any costs in excess of the benefits payable by my insurance plan.

Patient's Signature: _____ Date: _____

EYE HEALTH HISTORY

Date of last exam: _____ Doctor: _____
 Do you currently wear glasses: Yes No How old are your glasses: _____
 If so, do you wear them (circle one): all the time reading/near work distance tasks only occasionally work safety
 Have you ever worn contacts? Yes No Do you currently wear contacts? Yes No
 Describe any problems with your contacts: _____
 Are you interested in wearing contact lenses? Yes No
 If so, what style? Tinted Disposable Gas permeable Toric Bifocal Unsure
 How many hours per day do you work on a computer? _____
 Are you interested in refractive surgery? Yes No

Please circle to indicate if you have had any of the following:

Bloodshot Eyes	Discharge from Eyes	Fainting Spells	Loss of Vision
Blurred Vision Near	Dizzy Spells	Floaters, Spots	Migraine Headaches
Blurred Vision Far	Double Vision	Fluctuating Vision	Red Eyes
Burning Eyes	Dry Eyes	Glaucoma	Red Eyes
Cataracts	Eye Infection	Headaches	Seeing Halos
Color Vision, Poor	Eye Injury	Itching Eyes	Seeing Flashes
Crossed Eyes	Eye Strain	Light Sensitive	Sties, Chalazion
Watering Eyes	Vision Poor	Twitching Eyelid	Temporary Loss of Vision

MEDICAL HISTORY

Primary Care Physician _____

Do you have allergies to medications? Yes No If so please list: _____

List any medications that you take: _____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

Are you pregnant or nursing? Yes No

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

Please check yes or no

System	YES	NO		YES	NO
Constitutional			Gastrointestinal		
Fever, weight loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary			Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease/Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal		
Neurological			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness, tingling Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine			Respiratory		
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Mouth, Throat			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Earaches or drainage	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular		
Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss or injury	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Hematological/Lymphatic		
Genitourinary			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric		
Cervical/Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immunologic			Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Immune Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>			

If you answered yes to any of the above or have a condition not listed, please list: _____

FAMILY MEDICAL HISTORY

Please list any medical disease that runs in your immediate family: _____

OCULAR DISEASE

Does anyone in your immediate family have: Glaucoma , Macular Degeneration Other

Please List _____

SOCIAL HISTORY

Do you drive? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long? _____

Do you drink alcohol? Yes No If yes, type/amount/how long? _____

Do you use illegal drugs? Yes No If yes, type/amount/how long? _____

Have you been exposed to or infected with: HIV Hepatitis

Dr's Initials _____ Date _____