

PATIENT INFORMATION - Please complete all information. Please print.

E-MAIL ADDRESS: \_\_\_\_\_

Patient's Last Name	First Name	Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date
Home Address	City		State	Zip
Home Phone (    ) Cell Phone (    )	Work Phone (    )	Social Security #		
Employer or School	Address	Occupation		
Referred By	Type of Insurance Vision & Medical - Company Name / I.D. or Health Care# <input type="checkbox"/> Managed Care <input type="checkbox"/> HMO <input type="checkbox"/> Medical Health <input type="checkbox"/> Vision <input type="checkbox"/> Medicare <input type="checkbox"/> Other			
Signature (If patient is under 18, parent signature required) HIPAA Notification (Initial Please) _____			Date	

**PATIENT HISTORY -Please complete all information**

\* Primary reason for today's visit \_\_\_\_\_

\* Date of last eye exam: \_\_\_\_\_ By Dr : \_\_\_\_\_ Age of current glasses: \_\_\_\_\_

\* Name of primary physician: \_\_\_\_\_ Date of last medical exam: \_\_\_\_\_

**Return patients: If all of below is the same as last visit check here:**

- Have you or any of your family members visited our offices before?     Yes    No    If yes, who and when: \_\_\_\_\_
- Have your eyes been dilated before?     Yes    No    If yes, when: \_\_\_\_\_
- Have you had retinal photographs taken before?     Yes    No    If yes, when: \_\_\_\_\_
- Currently Pregnant?     Yes    No    If yes, how far along? Complications? \_\_\_\_\_
- Are you being treated for any medical condition(s)?     Yes    No    If yes, what: \_\_\_\_\_
- Are you taking any medications, vitamins or herbs?     Yes    No    If yes, what: \_\_\_\_\_
- Are you allergic to any medications?     Yes    No    If yes, which ones: \_\_\_\_\_
- Do you smoke cigarettes?     Yes    No
- Are your sunglasses and/or sports eyewear up to date?     Yes    No

	Self	Relative		Self	Relative	
Glaucoma	_____	_____	Thyroid	_____	_____	Dry, Itch or Pain in eyes _____
Cataracts	_____	_____	Asthma	_____	_____	Blurred Vision (when?) _____
Diabetes	_____	_____	Heart Disease	_____	_____	Frequent Headache _____
Retinal Diseases	_____	_____	Lung Disease	_____	_____	how often / where? _____
High Blood Pressure	_____	_____	Eye Disease	_____	_____	Double Vision _____
						Eye Infection _____
						Eye Surgery _____
						Night Vision Problems _____

- Do you work on a computer     Yes    No    If yes, how many hours a day? \_\_\_\_\_
- Are you interested in discussing corrective eye surgery?     Yes    No
- List sports and hobbies you participate in: \_\_\_\_\_

**CONTACT LENS INFORMATION**

- Is there any time you would like to do without your glasses?? \_\_\_\_\_
- Have you ever worn contact lenses?     Yes    No    If yes, what type and when: \_\_\_\_\_
- Are you interested in new contact lenses?     Yes    No    Bifocal / 1-Day / 30-Day / Tinted / 2 week
- If you wear contact lenses now, please answer the following:
 

Type	<input type="checkbox"/> Gas Perm	<input type="checkbox"/> Soft	<input type="checkbox"/> Disposable	<input type="checkbox"/> Astigmatism (toric)	<input type="checkbox"/> Monovision	<input type="checkbox"/> Bifocal
Method of wear	<input type="checkbox"/> Daily Wear		<input type="checkbox"/> Extended Wear ( how long between removal _____		how long to dispose of _____ )	
Care System	Brand: _____		Ever had a reaction to drops or solutions? What kind? _____			