

WELCOME TO OUR OFFICE

Is there a problem with your eyes or vision? Please describe: _____

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Home Phone: _____

City, State & Zip: _____ Work Phone: _____

E-Mail Address: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Gender: M or F Last Eye Exam: ____ / ____ / ____

Name(s) and age(s) of family members living at home: _____

Responsible Party or Bill Payer: _____ Relationship: _____

Medical Doctor: _____ Phone: _____ Last Med Exam: ____ / ____ / ____

How did you hear about our office? _____

Vision and Medical Insurance Information (Please show medical insurance card):

Member's Name: _____ Relationship to Patient: _____

Date of Birth: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Employer: _____

Vision Insurance: _____ Medical Insurance: _____

Medical History:

Do you have any medication or environmental allergies? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injuries or eye surgeries _____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your current pair? _____

Do you wear contact lenses? no yes If yes, how old and what type are your current pair? _____

Social History:

This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe: _____

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

*** Please turn this form over and complete side two ***

