

**WELCOME! We're happy to have you as our patient.
In order to provide the best possible care for you, please complete the form below.**

Name : _____

Today's Date: _____

Address: _____

Home Phone: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Date of Birth (M/D/Y): _____ Age: _____ Sex: M F

Work Phone: _____

Email: _____

Employer or School (if patient is a student): _____

Occupation (or grade): _____

Guardian Name & Relationship (if applicable): _____

Would you like to receive a text message reminder on your cell phone for your appointments? Yes No

PERSONAL EYE HISTORY

What is the main reason for your visit today? _____

When was your last eye exam? (Approximately) _____

Had any Eye surgeries? : None Lasik/PRK RK Cataract Retina Crossed Eyes Other _____

Do you wear **GLASSES**? Yes No

-Do you have them with you **TODAY**? Yes No

-When do you wear your glasses? Full time Reading only Distance/ Driving only Computer Use While not wearing contact lenses

Describe your Computer use: Extensive (5+ hrs. /day) Moderate (2-4 hrs. /day) Low (2hr/day or less) Rarely

Do you currently wear **CONTACT LENSES**? Yes No

-What Brand are your contacts? _____ What solution do you use on your contacts? _____

-How many days/week do you wear your contacts? _____ How many hours/day do you wear contacts? _____

-How often do you replace your lenses with new lenses? _____ Do you sleep in your contacts? Yes No

DO YOU CURRENTLY, OR HAVE YOU EVER HAD ANY ISSUES IN THE FOLLOWING AREAS?

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Blurred Near vision | <input type="checkbox"/> Dryness | <input type="checkbox"/> Loss of central vision | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Blurred Distance vision | <input type="checkbox"/> Excess tearing/watering | <input type="checkbox"/> Loss of side vision | <input type="checkbox"/> Flashes of light |
| <input type="checkbox"/> Glare at night | <input type="checkbox"/> Itching | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Floaters in vision |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Chronic infection of eye or lids | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Crossed Eyes |
| <input type="checkbox"/> Eye Injuries | <input type="checkbox"/> Eye Pain/Soreness | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Patching |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Burning | <input type="checkbox"/> Mucous Discharge | <input type="checkbox"/> Bumps/Styes |

SEE BACK OF PAGE TO COMPLETE

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<input type="checkbox"/> Medical Insurance Name: _____ Plan: _____ CoPay: _____ Refraction: _____ _____ _____ _____	<input type="checkbox"/> Vision Insurance Name: _____ Plan: _____ CoPay: _____ Refraction: _____ Contact Benefit: _____ Auth #: _____ _____ _____ _____	<input type="checkbox"/> Private Pay Optomap: <input type="checkbox"/> Yes <input type="checkbox"/> No Schedule Next Appointment For: <input type="checkbox"/> ___ Days(s) <input type="checkbox"/> PRN <input type="checkbox"/> ___ Weeks(s) <input type="checkbox"/> Annual <input type="checkbox"/> ___ Month(s) <input type="checkbox"/> No Charge <input type="checkbox"/> Give this back to Doctor
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Personal Medical History

(Many general medical conditions affect the eye and your vision)

The name of your Primary Care Physician / Medical Doctor is: _____

Do you take any prescription or non-prescription medicines regularly? Yes No (if yes, please list all medicines below)

Do you have allergies to any MEDICATIONS? None known Penicillin Sulfa drugs Other: _____

Do you have any problems listed with in the following medical systems? (Please check all that apply)

Please check this box if you DO NOT have any medical conditions to report.

Constitutional

- Cancer
- Fatigue
- Fever
- Weight loss
- Other _____

Allergic/Immunologic

- Seasonal allergies
- Environmental Allergies
- Rheumatoid arthritis
- Lupus
- Other _____

Cardiovascular

- Heart disease
- Vascular disease
- High Blood Pressure
- Stroke
- High Cholesterol

Genitourinary

- Urinary tract infections
- Kidney concerns
- STD: Herpes, Chlamydia, HIV

Ears, Nose & Throat

- Upper respiratory infection
- Sinus infection
- Head Cold

Neurological

- Multiple sclerosis
- Epilepsy
- Migraines
- Other _____

Endocrine

- Type 1 Diabetes
- Thyroid Dysfunction
- Type 2 Diabetes
- Hormonal Dysfunction

Blood/Lymphatic

- Anemia
- Leukemia
- Other _____

Psychiatric

- Depression
- Panic Disorder
- Schizophrenia
- Other _____

Others not listed: _____

Gastrointestinal

- Crohn's disease
- Colitis
- GERD
- Ulcer
- Other _____

Musculoskeletal

- Fibromyalgia
- Muscular dystrophy
- Osteoarthritis
- Other _____

Integumentary / Skin

- Eczema
- Rosacea
- Psoriasis
- Other _____

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Other _____

Family History Is there any family history of any of the following?

(If yes, please list their relationship to you)

- No Known Family History
- Blindness _____
- Cataract(s) _____
- Glaucoma _____
- Lazy Eye/Eye turn _____
- Macular _____
- Adopted – Family History Not Known
- Retinal _____
- Cancer _____
- Diabetes _____
- Heart Disease _____
- Hereditary Disease _____
- High Blood Pressure _____
- Lupus _____
- Thyroid Disease _____
- Other(s) _____

Social History (This information is kept strictly confidential; however, you may discuss this portion directly with the doctor if you prefer.)

Are you a: Non- Smoker Former Smoker Occasional Smoker Every Day Smoker Chewing Tobacco User THC Product User

Do you use alcoholic beverages? Yes No If yes, type/amount/how long: _____

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

Are you pregnant? Yes No

Currently Nursing? Yes No

Privacy Policy: The most common reason why we use or disclose your health information is for treatment, payment or health care operations. We may call or email to remind you of scheduled appointments. We will not make any other uses or disclosures of your health information unless you sign below. I agree that this consent is valid until I revoke it in writing. I understand I may request to read the full text of our privacy policy at any time.

I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name(s) & Relationship: _____

Signature of Patient/Responsible Party

Date