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?

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

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❑ Medical Insurance
Name:_____
Plan: _____
CoPay: _____
Refraction: _____

❑ Vision Insurance
Name:_____
Plan:_____
CoPay: _____
Refraction:_____
Contact Benefit:_____
Auth #:_____

❑ Private Pay

Optomap: ❑ Yes ❑ No

_____

_____

_____

Schedule Next Appointment For:
- ❑ ____Days(s)
- ❑ ____Weeks(s)
- ❑ ____Month(s)
- ❑ Give this back to Doctor
- ❑ PRN
- ❑ Annual
- ❑ No Charge

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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**