PATIENT INFORMATION

EXAM DATE___/___/___

LAST NAME_____ FIRST NAME_____ ☐M ☐F DOB___/___/___

ADDRESS_____ CITY_____ STATE_____ ZIP_____

1ST PHONE(___)_____ ☐HOME ☐WORK ☐CELL 2ST PHONE(___)_____ ☐HOME ☐WORK ☐CELL

EMPLOYER_____ OCCUPATION_____

EMAIL ADDRESS_____ REFERRED BY_____

INSURANCE INFORMATION

PLAN NAME_____ GROUP_____

INSURED NAME_____ RELATION TO PATIENT: ☐SELF ☐SPOUSE ☐ CHILD

INSURED ID#_____ INSURED DOB___/___/___

MEDICAL AND OCULAR HISTORY

REASON FOR TODAY'S VISIT: _____

ARE YOU PLANNING TO GET NEW GLASSES TODAY? ☐ YES ☐ NO

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? ☐ YES ☐ NO

DO YOU REGULARLY WEAR SUNGLASSES? ☐ YES ☐ NO

DATE OF LAST EYE EXAM? ___/___/___ DOCTOR? _____

AGE OF CURRENT GLASSES_____ BRAND OF CURRENT CONTACTS_____

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING CONDITIONS?

	SELF	REL.	NONE	PROBLEMS WITH:	YES	NO		YES	NO
DIABETES	☐	☐	☐	(SELF ONLY)			DO YOU SEE DOUBLE?	☐	☐
HIGH BLOOD PRESURE	☐	☐	☐	GENERAL HEALTH	☐	☐			
THYROID PROBLEMS	☐	☐	☐	EAR/NOSE/THROAT	☐	☐	FREQUENT HEADACHES?	☐	☐
HEART DISEASE	☐	☐	☐	RESPIRATORY	☐	☐	PREGNANT?	☐	☐
CANCER	☐	☐	☐	GASTROINTESTINAL	☐	☐	BEEN DILATED IN PAST? YEAR_____	☐	☐
GLAUCOMA	☐	☐	☐	GENITOURINARY	☐	☐			
CATARACTS	☐	☐	☐	MUSCULOSKELETAL	☐	☐	DO YOU SMOKE? PACK/DAY_____	☐	☐
RETINAL DISEASE	☐	☐	☐	SKIN	☐	☐			
EYE SURGERY	☐	☐	☐	NEUROLOGICAL	☐	☐	DRINK ALCOHOL? DRINKS/WK_____	☐	☐
EYE INJURY	☐	☐	☐	PROSTATE	☐	☐			
CROSSED/ LAZY EYE	☐	☐	☐	DEPRESSION	☐	☐	DRIVE A CAR?	☐	☐

PLEASE EXPLAIN ANY POSITIVE FINDINGS_____

PLEASE LIST ALL MEDICATIONS (Including eye drops, over the counter meds and birth control)_____

DO YOU HAVE ANY ALLERGIES (Medication, food, latex, seasonal, other)_____

SIGNATURE_____ DATE_____