Welcome to our Office

Date:___________________

Name: ____________________________________ Cell Phone: ______________________________

Date of Birth: _____/_____/______ Age________ Business Phone: _______________________________

Social Security: ______________________________ Home Phone: ______________________________

Address:____________________________________ City:_________________________ Zip________________

Email: ____________________________________ If a child, parents name: ______________________________

Employer___________________________________ Occupation/Position ______________________________

If in school, where do you attend: ______________________________ Grade/Year: _____________________

Who referred you to our office: ____

Vision Insurance ____________________________ ID# ______________________________

Medical Insurance: ___________________________ ID# _________________________ Supplm. Ins.____________

Primary Member: ____________________________ ID# __________________________ DOB#_________________

Primary Care Physician: _____________________________ Are you under a physician's care? _________________

Current Medications: ☐ None ☐ Yes ____

Medication Allergies: ☐ None ☐ Yes ____

Tobacco Use: ☐ Never Smoked ☐ Current Smoker ☐ Former Smoker **Alcohol Use:** ☐ No ☐ Social ________

Vision History

Last eye exam: __________________________________ By Whom: __________________________________

Do you wear glasses? ☐ Yes ☐ No If so, when worn? __________________________________

When wearing glasses, is your vision blurred at: ☐ Distance ☐ Near ☐ Computer ☐ Night ☐ Other _________

Are you interested in new glasses? ☐ Yes ☐ Possibly, if needed or changed ☐ No, not at this time

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Contact Lenses

If not wearing contact lenses, are you interested in being fitted?_____________________________________

If currently wearing contact lenses, do you need new/more lenses? _________________________________

Type of contact lenses: ☐ Soft ☐ Gas Permeable ☐ Other _________________ Brand ______________

How are they worn? ☐ Daily Wear ☐ Extended Wear ☐ Occasional Overnight Wear _______________________

Percent of time worn (100%, 50%, occasionally, etc.) ____

How often do you replace your lenses? ☐ Daily ☐ 2 weeks ☐ Monthly ☐ Other _________________________

Are your lenses comfortable? _________________ Do you see well with your current contact lenses? __________

Ocular Symptoms **(Check if occur)** **Comments/Other**

- ☐ Eyes tired
- ☐ Eyes itch
- ☐ Eyes water
- ☐ Eyes Red
- ☐ Discharge
- ☐ Light sensitive
- ☐ Dry Eyes
- ☐ Pain
- ☐ Flashes
- ☐ Floaters
- ☐ Styes
- ☐ See Double

Ocular Conditions **Comments/Other**

- ☐ Amblyopia (lazy eye)
- ☐ Strabismus (eye turn)
- ☐ Color Deficient
- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal tear/detachment
- ☐ Eye Injury
- ☐ Eye Surgery

Medical History **Do you have any of the following?** **Comments/Other**

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Condition
- ☐ Arthritis
- ☐ Allergies
- ☐ Sinus Issues
- ☐ Anxiety/Depression
- ☐ HIV +

Have you been diagnosed with Diabetes? ☐ No ☐ Yes If yes, how long ago? ______________________________

Headaches ☐ No ☐ Yes How often? ____________________ What part of the head? ____________________

Are they dull, sharp, severe, migraine?_____________________________ When do they occur?______________________

Family Medical History: **Relationship**

- ☐ Glaucoma ______________________________________
- ☐ Diabetes ______________________________________
- ☐ Macular Degeneration ______________________________________
- ☐ Crossed eyes ______________________________________

Refractive Surgery

Are you interested in a refractive surgery procedure? (Lasik, PRK, etc.) ☐ Yes ☐ No ☐ Possibly later

Other conditions which may be significant?

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____ ____________________________

Patient Signature *Date*

I have been provided the opportunity to review the Notice of Privacy Practices