WELCOME TO OUR OFFICE!

(PLEASE PRINT)

TODAY'S DATE_____ DATE OF BIRTH_____/_____/_____ AGE_____ SEX: M F

FULL NAME_____ SOCIAL SECURITY NUMBER_____

NICKNAME OR PREFERRED NAME_____ EMPLOYER (or SCHOOL)_____

ADDRESS_____ OCCUPATION (or GRADE)_____

CITY_____STATE_____ZIP_____ BUSINESS PHONE_____

HOME PHONE_____CELL PHONE_____ FAMILY PHYSICIAN AND DATE OF LAST MEDICAL EXAM

EMAIL ADDRESS_____ _____

CHILD LIVES WITH: MOTHER - FATHER - BOTH - GRANDPARENTS - OTHER _____

SPOUSE OR PARENT NAME_____ EMPLOYER_____

DATE OF BIRTH_____/_____/_____ AGE_____ SEX: M F OCCUPATION_____

SOCIAL SECURITY NUMBER_____ _____

PATIENT HEALTH HISTORY

Have we seen anybody in your immediate family? Y N

If yes, may we have their name and relation?_____

List sports or recreational activities_____

List any hobbies_____

How did you learn about out office?

_____Friend/Relative Who?_____

_____Another health care practitioner Who?_____

_____Yellow Pages_____Insurance _____Location _____Other

DO YOU…..

Have more than one pair of glasses?	Y	N
Want information on thinner, lighter lenses?	Y	N
Have prescription sunglasses?	Y	N
Have problems with glare at night when driving?	Y	N
Work on a computer for long periods?	Y	N

Do you have any allergies to medicines? Y N If yes, explain: _____

_____

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

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had:_____

_____

_____

List any of the following that you have or have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye injury or infection_____

When was your last eye exam and who was the doctor? _____

Are you pregnant and/or nursing? Y N

Do you wear glasses? Y N If yes, how old is your present pair of lenses? _____

Do you wear contacts? Y N If yes, how old is your present pair of lenses? _____

If yes, what type of contacts? Rigid Soft Extended Wear CRT Other Are they comfortable? Y N

PAYMENT / CO-PAYMENT IS EXPECTED AT THE TIME OF SERVICE. THANK YOU!

I hereby authorize the release of any medical and/or other information necessary to process this claim. I also authorize my insurance benefits to be paid directly to the optometrist and understand that I will be financially responsible for any service not paid in full by my insurance company.

SIGNED: _____ DATE: _____

Account will be settled today by: CHECK CASH CREDIT CARD DEBIT CARD INSURANCE

DATE:_____

_____ DATE:_____

Doctor's Signature DATE:_____

(CONTINUED ON BACK OF PAGE)

FAMILY HISTORY Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE / CONDITION				RELATIONSHIP TO YOU
Blindness	Y	N	?	
Cataracts	Y	N	?	
Crossed Eyes	Y	N	?	
Glaucoma	Y	N	?	
Macular Degeneration	Y	N	?	
Retinal Detachment / Disease	Y	N	?	
Arthritis	Y	N	?	
Cancer	Y	N	?	
Diabetes	Y	N	?	
Heart Disease	Y	N	?	
High Blood Pressure	Y	N	?	
Lupus	Y	N	?	
Thyroid Disease	Y	N	?	
Other _____	Y	N	?	

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

_____YES, I would prefer to discuss my social history with my doctor.

Do you drive? Y N If yes, do you have visual difficulty when driving? Y N If yes, please describe: _____
_____

Do you use tobacco products? Y N If yes, type / amount / how long? _____
Do you drink alcohol? Y N If yes, type / amount / how long? _____
Do you use illegal drugs? Y N If yes, type / amount / how long? _____
Have you ever been exposed to or infected with: _____ Gonorrhea _____ Hepatitis _____HIV _____Syphilis

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas?

CONSTITUTIONAL			
Fever, Weight Loss / Gain	Y	N	?
INTEGUMENTARY (Skin)	Y	N	?
NEUROLOGICAL			
Headaches	Y	N	?
Migraines	Y	N	?
Seizures	Y	N	?
EYES			
Loss of Vision	Y	N	?
Blurred Vision	Y	N	?
Distorted Vision / Halos	Y	N	?
Loss of Side Vision	Y	N	?
Double Vision	Y	N	?
Dryness	Y	N	?
Mucous Discharge	Y	N	?
Redness	Y	N	?
Sandy or Gritty Feeling	Y	N	?
Itching	Y	N	?
Burning	Y	N	?
Foreign Body Sensation	Y	N	?
Excess Tearing / Watering	Y	N	?
Glare Light Sensitivity	Y	N	?
Eye Pain or Soreness	Y	N	?
Chronic Infection of Eye	Y	N	?
Styes or Chalazion	Y	N	?
Flashes / Floaters in Vision	Y	N	?
Tired Eyes	Y	N	?
ENDOCRINE			
Thyroid / Other Glands	Y	N	?

EARS, NOSE, THROAT, MOUTH			
Allergies / Hay Fever	Y	N	?
Sinus Congestion	Y	N	?
Runny Nose	Y	N	?
Chronic Cough	Y	N	?
Dry Throat / Mouth	Y	N	?
RESPIRATORY			
Asthma	Y	N	?
Chronic Bronchitis	Y	N	?
Emphysema	Y	N	?
VASCULAR / CARDIOVASCULAR			
Diabetes	Y	N	?
Heart Pain	Y	N	?
High Blood Pressure	Y	N	?
Vascular Disease	Y	N	?
GASTROINTESTINAL			
Crohn's Disease	Y	N	?
Inflammatory Bowel Disease	Y	N	?
Ulcerative Colitis	Y	N	?
GENITOURINARY			
Genitals / Kidney / Bladder	Y	N	?
BONES / JOINTS/ MUSCLES			
Rheumatoid Arthritis	Y	N	?
Lupus	Y	N	?
LYMPHATIC / HEMATOLOGIC			
Anemia	Y	N	?
Bleeding Problems	Y	N	?
ALLERGIC / IMMUNOLOGIC	Y	N	?
PSYCHIATRIC	Y	N	?

If you answered YES to any of the above questions or have a condition not listed, please explain:_____

_____