



WELCOME TO OUR OFFICE

Today's Date _____
Last _____ First _____ Mi _____
Street _____
City _____ State _____ Zip Code _____
Home Phone _____
Work Phone _____
Patient SS# _____
Date of Birth _____ Age _____ Sex: M F
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent Name) _____
Spouse (or Parent Work #) _____
Email Address _____
What is the major purpose of this visit?

Any problems with your present contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
If not referred, how did you choose our office for your needs?
 Another Dr. Insurance List
 Saw Sign/ Building Newspaper/ Magazine/ Radio/ TV
 Yellow/ White Pages Community Event _____
 Internet: Web site _____
 Other _____

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SS# _____
Subscriber Birth Date _____

Do you participate in a Flex Spending Account? Yes No

Family Medical/ Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____

The information in this confidential case history is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____
Town _____
Date of last Physical Check -Up _____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins & birth control pills) _____

Allergies to Medications? Yes No
Explain _____
Have YOU ever been diagnosed or treated for the following?
 Allergies Cholesterol Kidney Disease
 Asthma Diabetes High Blood Pressure
 Arthritis Heart Disease Thyroid Disease
 Cancer Nerves Other

Patient Eye History

Date of last Eye Exam _____
By Whom? _____
Have you ever been diagnosed or treated for the following?
 Cataracts Iritis/ Uveitis
 Corneal Abrasion Lazy Eye
 Eye Infection Macular Degeneration
 Eye Injury Retinal Detachment
 Glaucoma Other eye disorders
Do you experience or have you ever experienced?
 Blurry Vision Grittiness Sunlight Sensitivity
 Burning Itchiness Occasional dryness
 Tearing Headaches Trouble seeing at night
 Discomfort Flash of light Crossed eye/ Eye turn
 Double Vision Floaters/ Spots

Contact Lens Wearers

Are you satisfied with your vision in your current lenses? Yes No
Are you satisfied with the comfort of your current lenses? Yes No

Lifestyle Questions

Do you..... (Check box if answer is YES)?
 Work at a computer?
 Have interest in "Test Driving" the latest contact lens design?
 Spend a lot of time outdoors? Hours/ Week? _____
 Have prescription glasses?
 Prefer not to wear your glasses at times?
 Want information on Laser Correction Surgery?
 Have interest in a non-surgical approach to vision correction?
 Have more than 1 pair of current Rx glasses?
 Have children?
 Have family members in need of eye care?
 Have you ever tried contact lenses?
 Are you interested in colored contacts?
Bifocal wearers: Do the lines or head tilting bother you? Y N