WELCOME TO OUR OFFICE

Today's Date ______________________

Last ___________________ First _________________ Mi _____

Street ____

City ___________________ State _______ Zip Code _________

Phone: Home (____)__________________________________

Daytime (____)______________Mobile (____)____________

How would you prefer to be contacted? __Email __Text __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?

- □ Insurance List Which one?__________________________
- □ Another Dr. Who?_________________________________
- □ Friend/ Family Who? _______________________________
- □ Community Event Which one?________________________
- □ Internet: Web site ___________________________________
- □ Newspaper/ Magazine/ Radio □ Saw Sign/ Building
- □ Other ____

Insurance Information

Vision Insurance ______________________________________

Are you the primary Insurance subscriber? Yes No

If no, please fill out information below.

Subscriber Name ______________________________________

Subscriber SS# _______________________________________

Subscriber Birth Date __________________________________

Family Medical/ Eye History (Check all that apply)

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

	Relationship
Blindness	□ ______________________
Cataracts	□ ______________________
Corneal Problems	□ ______________________
Glaucoma	□ ______________________
Lazy Eye	□ ______________________
Macular Degeneration	□ ______________________
Retinal Problems	□ ______________________
Diabetes	□ ______________________
Heart Disease	□ ______________________

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 __________________________

Height_________________ Weight _____________________

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

What brand of contacts do you currently wear? ________________

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?
- □ Do you have children?
- □ Have family members in need of eye care?
- □ Ever tried contact lenses? □ Interested in colored contacts?

Bifocal wearers: Do the lines or head tilting bother you? Y N