Welcome to our office!

Please fill out this form as completely as possible and return it to the desk.

Name of Doctor you wish to see: | Today's Date

Name | Email Address

Address | Home Phone

Apt.# | ☐ Male ☐ Female | Cell Phone

City | State | Zip Code | Work Phone

Date of Birth | SSN | Fax Phone

Primary Care Physician | Phone

Previous Eye Doctor | Phone

Last Eye Exam | Referred By

Vision Insurance Information

Insurance | Card Number or I.D.#

Cardholder | Group Number

Address | Apt.#

City | State | Zip Code | Date of Birth

Relationship to Insured: ☐ Child ☐ Spouse ☐ Other

Medical Insurance Information

Insurance | Card Number or I.D.#

Cardholder | Group Number

Address: | Apt.#

City | State | Zip Code | Date of Birth

Relationship to Insured: ☐ Child ☐ Spouse ☐ Other

Employer | Sports/Hobbies

Occupation | Emergency Contact | Phone

Please indicate student status if employment does not apply.

☐ I wear Glasses ☐ I wear contact lenses ☐ Soft ☐ Hard What brand of contact lens do you currently wear?

Are the contact lenses you are currently wearing comfortable? ☐ Yes ☐ No

Medical History

Allergies

Occular History

Medications

Injuries/ Surgeries

Family Medical History: Note relation to yourself in the box (example: "Mother", "Paternal Grandfather" etc.)

- ☐ Blindness
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detatchment
- ☐ Crossed Eyes
- ☐ Lupus
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Thyroid Disease

Other:

☐ Currently pregnant or nursing.

☐ Doesn't Drive ☐ Drives ☐ Doesn't Use Tobacco ☐ Uses Tobacco

Driving Difficulties

Type/Amount/How Long?

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol ☐ Doesn't Use Illegal Drugs ☐ Uses Illegal Drugs

Type/Amt/HowLong

Type/Amt/HowLong

Have you ever been exposed to or infected with ☐ Gonhorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV

Review of Systems. Please check all that apply to you.

Eyes
- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excess Watering
- ☐ Light Sensitivity
- ☐ Eye Pain/Soreness
- ☐ Chronic Infection
- ☐ Sties
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detatchment

Gastrointestinal
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea

Constitutional
- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Fatigue
- ☐ Trauma

Integumentary (Skin)
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Neurologic
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

Endochrine
- ☐ Non Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Cardiovascular
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia

Ears/Nose/Throat
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Allergic/Immune
- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Lupus
- ☐ Arthritis

Lymphatic/Hematologic
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spond.

Genitourinary
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ STD's

Please list any other symptoms you may be experiencing.