WELCOME TO OUR OFFICE!

PATIENT INFORMATION

Today's Date ______________

Name (Mr/Mrs/Miss) ____ SS # ______________ Birthdate ________
(Last) (First) (Middle)

Address ________________________________ City ______________ Zip Code __________

Home Phone# ______________ Cell/Work Phone# ______________ Email: ______________

Occupation ______________ If student: Grade ______ LAST EYE EXAM: ______________

Employed by ______________ Telephone # ______________

Vision Insurance: Yes _____ No _____ Name of Insurance Co. ______________

Name of Medical Insurance ______________________________

Name and age of each child living at home:

Name	Age	Name	Age

PARENT OR SPOUSE INFORMATION

Name ________________________________ Social Security # ______________

Occupation ______________ Employed by ______________ Phone # ______________

Vision Insurance Yes _____ No _____ Name of Insurance Co. ______________

HEALTH INFORMATION

GENERAL HEALTH: Do you have/had any of the following symptoms (CHECK if Yes):

___ Allergies ___ Drug Allergies ___ Headaches ___ **DIABETES** ___ High Blood Pressure
___ Fainting ___ Skin Condition ___ Surgical Condition ___ Asthma ___ Thyroid Disease
___ Eye surgery ___ Eye Diseases ___ Eye/head injury ___ Glaucoma ___ Hayfever

FAMILY HISTORY: Has anyone in your family had:

___ Diabetes ___ High blood Pressure ___ Heart Disease ___ Stroke ___ Thyroid Disease
___ Glaucoma ___ Blindness ___ Cataract ___ Macular Degeneration ___ Retinal Detachment ___ Lazy Eye ___ Crossed Eyes

Are you presently taking any medication including birth control pill? __ If so, please state their names ______________

____

Do you use Cigarettes/Tobacco? ______________ Alcohol? ______________ Other Substances? ______________
Date of last general health exam __________ Any abnormalities reported from this exam? ______________

REASON FOR TODAY'S VISIT: ______________________________

Do you experience any of the following symptoms:

___ Burning ___ Seeing spots ___ Flashing Lights ___ Sensitivity to lights ___ Eye Ache ___ Double vision
___ Dry Eyes ___ Itch ___ Tired eyes ___ Twitching eye lids Other ______________

Have you ever worn Contact Lenses? Y / N If Yes, do you wear them now? Y / N What kind/Name: ______________
Are you interested in wearing them? Y / N
Who may we thank for referring you to our office? ______________

Doctor's Initials: ______________