**PATIENT INFORMATION** – Please complete all information. Please Print

| E-Mail: Address: | | | | |
|---|---|---|---|---|
| Patient's Last Name | First Name | Initial | ☐ Male ☐ Female | Birth Date |
| Home Address | City | State | Zip | |
| Home Phone ( )<br>Cell Phone ( ) | Work Phone ( ) | Social Security # | | |
| Employer or School | Address | Occupation | | |
| Referred By | Type of Insurance Vision & Medical- Company Name / I.D. or Health Care#<br>☐ Managed Care ☐ HMO ☐ Medical Health ☐ Vision ☐ Medicare ☐ Other | | | |
| Signature (if Patient is under 18, Parent Signature required)<br>HIPAA Notification (Initial Please)_______________ Date: | | | | |

**PATIENT HISTORY-Please complete all information**

*Primary reason for today's visit______________________________________________________________

*Date of last eye exam:_____________By Dr___________________Age of Current Glasses______________

*Name of Primary Physician_________________________Date of last medical exam:__________________

**Return patients: if all of below is the same as last visit check here:** ☐

| | | | |
|---|---|---|---|
| • Have you or any of your family members visited our offices before? | ☐ Yes | ☐ No | If yes, who and when:__________________ |
| • Have your eyes been dilated before? | ☐ Yes | ☐ No | If yes, when:___________________________ |
| • Have you had retinal photographs taken before? | ☐ Yes | ☐ No | If yes, when:___________________________ |
| • Currently Pregnant? | ☐ Yes | ☐ No | If yes, how far along? Complications? ______ |
| • Are you being treated for any medical condition(s)? | ☐ Yes | ☐ No | If yes, what:___________________________ |
| • Are you taking any medications, vitamins or herbs? | ☐ Yes | ☐ No | If yes, what:___________________________ |
| • Are you allergic to any medications? | ☐ Yes | ☐ No | If yes, which ones:_____________________ |
| • Do you smoke cigarettes? | ☐ Yes | ☐ No | |
| • Are your sunglasses and / or sports eyewear up to date? | ☐ Yes | ☐ No | |

**Please check any that apply:**

| | Self | Relative | | Self | Relative | | Self |
|---|---|---|---|---|---|---|---|
| | | | | | | Dry, Itch or Pain in Eyes | _________ |
| Glaucoma | ________ | _________ | Thyroid | ________ | _________ | Blurred Vision (When?) | _________ |
| Cataracts | ________ | _________ | Asthma | ________ | _________ | Frequent Headache | _________ |
| Diabetes | ________ | _________ | Heart Disease | ________ | _________ | How often / Where? | _________ |
| Retinal Diseases | ________ | _________ | Lung Disease | ________ | _________ | Eye Infection | _________ |
| High Blood Pressure | ________ | _________ | Eye Disease | ________ | _________ | Eye Surgery | _________ |
| | | | | | | Night Vision Problems | _________ |

• Do you work on a Computer ☐ Yes ☐ No If yes, how many hour a day? _________________
• Are you interested in discussing corrective eye Surgery? ☐ Yes ☐ No
• List sports and hobbies you participate in : ______________________________________________________________

**CONTACT LENS INFORMATION**

• Is there any time you would like to do without your glasses? __________________________________________________________
• Have you ever worn contact lenses? ☐ Yes ☐ No If yes, what type and when:_____________________________________
• Are you interested in new contact lenses? ☐ Yes ☐ No Bifocal / 1-Dat / 30- Day / Tinted / 2 week

• If you wear contact lenses now, please answer the following:

Type ☐ Gas Perm ☐ Soft ☐ Disposable ☐ Astigmatism ☐ Monovision ☐ Bifocal

Method of Wear ☐ Daily Wear ☐ Extended Wear(How Long between removal_________ how long to dispose of ___________)

Care System Brand:___________________ Ever had a reaction to drops or solutions? What kind? _______________________________