Patient Information

Today's Date:____/____/____

Name: (last)_____, (first)_____ (initial)_____

Address:_____ City:_____ State:_____Zip:_____

Phone: (home)_____(work/cell)_____ D.O.B_____/_____/_____

Please circle the best number to reach you

Social Security #_____ Status: Mr. Ms. Miss. Mrs. Dr. Sex: M F

Email Address (responsible party) _____@_____

Birth State _____ Height _____ Weight _____ Mother's Maiden Name _____

Parent/Legal Guardian:_____ Relationship to Patient:_____

Medical Doctor_____City:_____ Last Exam Date:_____

Previous Eye Doctor_____City_____Last Exam Date:_____

Whom may we thank for referring you?_____

Medical History:

Allergies to medications or latex? Y N If yes, please list_____

List all medications/ Ocular medications you are currently taking _____

_____

List all major injuries, surgeries, illnesses, and hospitalizations you've had _____

_____

Are you currently pregnant or nursing? Y N Due Date_____

Do you currently wear glasses? Y N Age of lenses_____ Are you interested in new glasses today? Y N

Do you use a computer? Y N How many hours a day?_____

Do you currently wear contacts? Y N If yes, type of contact lenses: _____

When did you start wearing contact lenses?_____ Contacts last date worn_____

If no, are you now interested in trying contact lenses? Y N

Contact Lens design requires addition testing & an additional fee, which may not be covered by insurance

Are you interested in Refractive surgery? Y N (LASIK, PRK, CK, Lensectomy)? Y N

Profession:_____ Do you require special vision needs in your line of work? Y N

If yes, specify:_____

Self/Family History: Please note any family/self (blood related, living or deceased) history for the following conditions.

DISEASE/CONDITION	Self:	Yes	No	?	Family:	Yes	No	?	RELATIONSHIP TO YOU
Arthritis		☐	☐	☐		☐	☐	☐	_____
Diabetes		☐	☐	☐		☐	☐	☐	_____
Heart Disease		☐	☐	☐		☐	☐	☐	_____
High Blood Pressure		☐	☐	☐		☐	☐	☐	_____
Kidney Disease		☐	☐	☐		☐	☐	☐	_____
Thyroid Disease		☐	☐	☐		☐	☐	☐	_____
Amblyopia/ Lazy Eye		☐	☐	☐		☐	☐	☐	_____
Blindness		☐	☐	☐		☐	☐	☐	_____
Cataract		☐	☐	☐		☐	☐	☐	_____
Corneal Abrasion		☐	☐	☐		☐	☐	☐	_____
Crossed Eyes/ Strabismus		☐	☐	☐		☐	☐	☐	_____
Dry Eyes		☐	☐	☐		☐	☐	☐	_____

OVER

	Self: Yes	No	?	Family: Yes	No	?	
Glaucoma	☐	☐	☐	☐	☐	☐	_____
Herpes Simplex/Zoster	☐	☐	☐	☐	☐	☐	_____
Keratoconus/ Corneal Disease	☐	☐	☐	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	☐	☐	☐	_____
Recurrent Corneal Abrasion	☐	☐	☐	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	☐	☐	☐	_____
Sjrogrens Syndrome	☐	☐	☐	☐	☐	☐	_____
Ocular Trauma/ Foreign Body	☐	☐	☐	If yes, explain: _____			
Refractive Surgery (Lasik, PRK, RK)	Date/Type _____						

Social History: This information is kept *strictly* confidential. However, you may discuss this portion with the doctor directly if you prefer. ☐ Yes, I would prefer to discuss my social history directly with my doctor.

Do you drive? Y N Do you have any problems when driving? _____

Do you currently OR have you ever used tobacco? Y N How Often? _____

Do you drink alcohol? Y N How often? _____

Do you use illegal drugs? Y N type/amount/how long _____

Have you been exposed to/infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

Review of Self Systems: Do ***you*** currently, or have you ever, had any problems in the following areas?

SYSTEM	YES	NO	?
Constitutional			
-fever, weight loss/gain	☐	☐	☐
Integumentary (skin)			
- Healing Problems/Keloid	☐	☐	☐
-Psoriasis	☐	☐	☐
-Rosacae	☐	☐	☐
-Eczema	☐	☐	☐
Neurological			
-headaches	☐	☐	☐
-migraines	☐	☐	☐
-seizures	☐	☐	☐
Eyes			
-loss of vision	☐	☐	☐
-blurred vision	☐	☐	☐
-distorted vision/halos	☐	☐	☐
-loss of side vision	☐	☐	☐
-double vision	☐	☐	☐
-dryness	☐	☐	☐
-redness	☐	☐	☐
-sandy/gritty feeling	☐	☐	☐
-itching	☐	☐	☐
-burning	☐	☐	☐
-foreign body sensation	☐	☐	☐
-excess tearing/watering	☐	☐	☐
-glare/light sensitivity	☐	☐	☐
-eye pain or soreness	☐	☐	☐
-chronic infection (eye or lid)	☐	☐	☐
-sties or chalazion	☐	☐	☐
-flashes/floaters in vision	☐	☐	☐
Ears, Nose Mouth or Throat			
-allergies/hay fever	☐	☐	☐
-sinus congestion	☐	☐	☐
-runny nose	☐	☐	☐
-post-nasal drip	☐	☐	☐
-chronic cough	☐	☐	☐
-dry throat/mouth	☐	☐	☐
-Sjrogrens Syndrome	☐	☐	☐

SYSTEM	YES	NO	?
Gastrointestinal			
-Diarrhea	☐	☐	☐
-Constipation	☐	☐	☐
Genitourinary			
-Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
-rheumatoid arthritis	☐	☐	☐
-muscle pain	☐	☐	☐
-joint pain	☐	☐	☐
-Lupus	☐	☐	☐
Lymphatic/Hematologic			
-anemia	☐	☐	☐
-bleeding problems	☐	☐	☐
Allergic/Immunologic			
-mucous discharge	☐	☐	☐
-autoimmune disorder	☐	☐	☐
Psychiatric			
-Claustrophobic	☐	☐	☐
Vascular/Cardiovascular			
-diabetes	☐	☐	☐
-heart pain	☐	☐	☐
-high blood pressure	☐	☐	☐
-vascular disease	☐	☐	☐
- Pacemaker	☐	☐	☐
Respiratory			
-asthma	☐	☐	☐
-chronic bronchitis	☐	☐	☐
-emphysema	☐	☐	☐
Endocrine			
-thyroid/glandular problem	☐	☐	☐

If you checked yes to *any* of the above or have a condition not listed, please explain: _____

_____

_____

_____

_____

Patient Signature (Or parent if a minor) _____ Date _____