Welcome...

Date_____

Name_____ Date of Birth_____ Height _____ Weight _____

Address_____ Male____ Female____ Home Phone_____

City _____ State_____ Zip_____ Cell Phone _____

We can now notify you when your orders are ready for pick-up, appointment reminders, newsletters, and upcoming events via e-mail or text. If you would like access to your medical records, please see the front desk for a temporary password and instructions.

□ e-mail _____ Occupation _____

Vision Insurance_____ Medical Insurance_____

Social Security # of Responsible Person or Member ID _____

Reason for Visit? _____

When was your last eye exam? _____ Doctor's name _____

Have you had any eye surgeries, eye injuries, or serious eye diseases? Yes No If yes, please explain

_____

Can we dilate your eyes today and perform other medical testing (photos, visual field) if needed? Yes No

This may reflect additional copays and charges from your insurance. You will be responsible for payment.

Patient Visual Symptoms

Check those you have had

___Blurry Distance Vision
___Blurry Near Vision
___Light Sensitivity
___See Floaters or Spots
___Double Vision
___Eye Strain
___Temporary Loss of Vision
___See Flashing Lights
___Watery Eyes
___Headaches
___Dry Eye
___Burning Eyes
___Red Eyes
___Itching Eyes
___Vision Therapy

Patient's Health History

Check those you have had

___Depression
___Kidney Disease
___Arthritis
___Allergies
___Asthma
___Cancer
___Diabetes
___Heart Condition
___High Blood Pressure
___HIV/Aids
___Thyroid Condition
___Blindness/Reduced Vision
___Cataracts
___Glaucoma
___Macular Degeneration
___Turned Eye

Family Health History

Please list family member that has had

D=dad **M**=mom **Sis**=sister **B**=brother **GM**=grandmother **GF**=grandfather **S**=son **Dau**=daughter

_____Cancer
_____Diabetes
_____Heart Condition
_____High Blood Pressure
_____Blindness
_____Cataracts
_____Glaucoma
_____Macular Degeneration

Do you have any medical conditions not listed? _____

Do you smoke? Yes No

If you wear glasses, please answer the following questions:

When do you wear your glasses? All the time For distance only For near only

Do you wear contact lenses? Yes No Which type? Soft Hard

If you don't currently wear contacts, are you interested in trying them? Yes No

Please list any medications you are currently taking or give us a list to copy_____

_____

Are you allergic to any medication? (if yes, please list)_____

Who is your family physician? _____

Who can we thank for referring you to us? _____

Payment for professional services, copays, contact lens fitting fees , overages on insurance and or glasses/ contacts is due at time of appointment. Thank you.