PATIENT INFORMATION

PATIENT INFORMATION - Please complete all information. Please print.

Patient's Last Name	First Name	Initial	☐ Male ☐ Female	Birth Date
Home Address	City	State / Prov.	Zip / Postal	
Home Phone ( )	Work Phone ( )	email		
Employer or School	Address	Occupation		
Referred By	Insurance Name _____ Primary's DOB ____/____/____ Primary Policy Holder Name _____			
Signature (If patient is under 18, parent signature required)	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: _____
- Have you or any 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: _____
- Are you being treated for any medical condition? ☐ Yes ☐ No If yes, what: _____
- Are you taking any medications? ☐ Yes ☐ No If yes, which ones: _____
- Are you allergic to any medications? ☐ Yes ☐ No If yes, which ones: _____
- Please check any / all conditions that apply:

	Self	*Relative*		*Self*	*Relative*		*Self*
Glaucoma	____	____	Thyroid Problems	____	____	Dryness or Pain in eyes	____
Cataracts	____	____	Asthma	____	____	Blurred Vision	____
Diabetes	____	____	Heart Disease	____	____	Frequent Headaches	____
Retinal Disease	____	____	Lung Disease	____	____	Double Vision	____
High Blood Pressure	____	____	Eye Disease	____	____	Eye Infection	____
						Eye Surgery	____
						Night Vision Problems	____

- Do you work on a computer? ☐ Yes ☐ No If yes, how many hours a day? _____
- Are you interested in Corrective Eye Surgery? ☐ Yes ☐ No
- List sports and hobbies you enjoy participating in: _____

CONTACT LENS INFORMATION

- Have you ever worn contact lenses? ☐ Yes ☐ No If yes, what type and when: _____
- Are you interested in new contact lenses? ☐ Yes ☐ No
- If you wear contact lenses now, please answer the following:

Type: ☐ Hard ☐ Gas Perm ☐ Soft ☐ Disposable ☐ Astigmatism ☐ Bifocal ☐ Monovision
Method of Wear: ☐ Extended Wear ☐ Daily Wear ☐ Flexible Wear
Care System Brand: _____ Ever had a reaction to drops or solutions? _____