WELCOME TO OUR OFFICE! Date_______________

Name Ms/Mrs/Mr/Dr________________________________ Age________ Sex_________
Address________________________________ Date of Birth______________________
City______________________ State_______________ Zip Code__________________
Home Phone ( )__________________ Work Phone ( )__________________ Cell Phone ( )__________________
E-mail Address________________________________ Social Security Number ____________________
Communication Preference: E-Mail Postal Home Phone Cell Phone
Employer (or School)________________________________ Marital Status: S M W D
Occupation (or Grade)____
Spouse's Name (or Parent's)________________________________Approx. Date of Last Exam______________
Race__________________ Ethnicity__________________ Preferred Language__________________
Vision Insurance Plan____
Member's Name________________________________ Member's Date of Birth__________________
Member's Social Security Number________________________ ID/Contract #__________________
Medical Insurance Plan____
Member's Name________________________________ Member's Date of Birth__________________
Member's Social Security Number________________________ ID/Contract #__________________

Reason for Today's Visit

- Yearly Eye Exam □
- Contact Lens Exam □
- Eye Infection □
- Laser Vision Correction □
- Eye Injury □

Do you experience? (Check all that apply)

Eye Strain	□	Itchiness	□	Trouble close-up	□
Trouble learning	□	Redness	□	Burning	□
Double Vision	□	Headaches	□	Gritty feeling in eyes	□
Watery Eyes	□	Objects floating in vision	□		
Migraines	□	Sudden loss of vision	□		

Medical History (circle yes or no)

Allergies	Yes/No	Lasik	Yes/No
Asthma	Yes/No	Cancer	Yes/No
Diabetes	Yes/No	Arthritis	Yes/No
Macular Degen.	Yes/No	Heart Disease	Yes/No
Eye Injury	Yes/No	High B.P.	Yes/No
Eye Surgery	Yes/No	Lazy Eye	Yes/No
Cataracts	Yes/No	Glaucoma	Yes/No

Other________________________________
Drug Allergies________________________________
List Current Medications________________________
____
____
Do You Smoke? Yes/No

Are there times you would rather not wear glasses?	Yes/No
Do you currently wear contact lenses?	Yes/No
If not, do you want to know about them?	Yes/No
Do you wear prescription sunglasses?	Yes/No
Do you experience problems with glare or reflections, particularly while driving at night?	Yes/No
Do you spend a lot of time outdoors?	Yes/No
Do you work at a computer for long hours?	Yes/No
Do you have questions about laser refractive surgery?	Yes/No

What sport activities do you participate in? ______________
____
List hobbies____
____

Family Medical History Relationship
*Please indicate paternal or maternal

Blindness	Yes/No	________________
Diabetes	Yes/No	________________
Glaucoma	Yes/No	________________
Heart Disease	Yes/No	________________
Lazy Eye	Yes/No	________________
Macular Degen.	Yes/No	________________

Other ________________________________
____

How did you hear about our office?
□ Friend or Relative, Name of? __________________________
□ Another HealthCare Practitioner, Who? ________________
□ Website □ Yellow Pages □ Newspaper
□ Internet – which search engine? ______________________
□ Community Group/Event, which one? ________________
□ Location / Walk-in □ Other / Insurance_____________

Primary Care Physician ________________________________
Address ____
Phone / Fax ____

Please Sign Below

Patient Signature ____ Date ______________________