

Welcome to Our Office

Name: _____ Today's Date: _____
Birth Date: ____ / ____ / ____ Gender: M F SSN: ____ / ____ / ____
 Month Day Year
Primary Contact Phone #: _____ Secondary Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Occupation: _____
Vision Insurance Provider: _____ Medical Insurance Provider: _____
Who should we thank for referring you to our office? _____

Medical History

Last Eye Exam: ____ / ____ Last Eye Doctor: _____
 Month Year
Last Medical Exam: ____ / ____ Current Medical Dr.: _____
 Month Year
Do you have any allergies to medications? Yes No If yes, please explain: _____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies): _____

List any major injuries, surgeries, and/or hospitalizations you have had: _____

Check any of the following that you have had: <input type="checkbox"/> Reading Difficulty <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal Disease <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye Injury	
Are you pregnant and/or nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how old is your current pair of glasses? _____ How many pairs of glasses do you currently use? _____
Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how old is your current pair of contacts? _____	
Type of contact lenses: <input type="checkbox"/> Gas permeable <input type="checkbox"/> Soft <input type="checkbox"/> Extended wear <input type="checkbox"/> Other _____	
Are your contact lenses comfortable? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had refractive surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you bothered by glare from: Overhead lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No A computer screen <input type="checkbox"/> Yes <input type="checkbox"/> No Incoming headlights at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
At work: Do you perform fine or close-up work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you outdoors all or part of the time? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is safety protection a concern at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are your eyes sensitive in bright sunlight? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have trouble reading signs when driving at night? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What hobbies or recreational sports do you enjoy? _____	

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)
Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No
If yes, please describe: _____
Do you use tobacco products? Yes No If yes, type/amount/how long: _____
Do you drink alcohol? Yes No If yes, type/amount/how long: _____
Do you use recreational drugs? Yes No If yes, type/amount/how long: _____
Have you been exposed to or infected with:
 Gonorrhea Hepatitis HIV Syphilis No, I have not.

*** Please turn this form over ***

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease / Condition	Yes	No	Not Sure	Relationship to You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Systemic Disease / Condition	Yes	No	Not Sure	Relationship to You
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	Not Sure	System	Yes	No	Not Sure
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine			
Constitutional				Thyroid/ Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat			
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/ Cardiovascular			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy/Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury / Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea/ Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess Tearing/Wate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Light Sensivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/ Joints/ Muscles			
Eye Pain or Sorenes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/ Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stye or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic			
Flashes/ Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/ Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Signature _____

Date: _____

I have read and understand the Notice of Privacy Practices.

Patient's Signature _____

Date: _____