Patient Information

Name_____ Age_____ Birth date_____
last first

Address_____ City_____ State _____Zip_____

SSN_____ Home Phone#_____ Work / Cell Phone#_____

In case of an emergency, contact _____Phone #_____

Insurance information

Name of insured_____ Relationship to patient_____

Birth date _____ Social security #_____ Health insurance provider_____

Vision insurance provider _____ Secondary insurance provider _____

Health History

Date of last eye exam_____ Name of doctor_____

Phone #_____

Primary Care Physician_____ Date last seen_____

Phone #_____

Do **YOU** have any history of the following?

[ ] Diabetes	[ ] Blindness	[ ] High blood pressure	[ ] Thyroid disease
[ ] Turned or lazy eye	[ ] Glaucoma	[ ] Heart condition	[ ] Macular Degeneration
[ ] Cataracts	[ ] Migraines	[ ] Cancer	[ ] Autoimmune condition

Have **YOU** been exposed/infected with the following?

[ ] Hepatitis [ ] HIV [ ] Chlamydia [ ] Syphilis

Please check any of the following that apply to **YOU**:

[ ] Frequent headaches [ ] Drug allergies [ ] Pregnant [ ] Allergies

[ ] Sinus trouble [ ] Alcohol / Tobacco use [ ] Illegal drug use

Does your **FAMILY** have any history of the following?

[ ] Diabetes [ ] Blindness [ ] High blood pressure [ ] Thyroid disease

[ ] Turned or lazy eye [ ] Glaucoma [ ] Heart condition [ ] Macular degeneration

[ ] Cataracts [ ] Migraines [ ] Cancer [ ] Autoimmune condition

Please list all medications you are currently taking:

_____

_____

_____

_____

Please list any known allergies you have:

_____

Have you ever had any of the following conditions involving your eyes:

[ ] Eye surgery [ ] Sensitivity to light [ ] Eye infection or disease [ ] Eye injury

[ ] Floaters or spots [ ] Double vision [ ] Medical treatment [ ] Poor near vision

[ ] Poor distance vision [ ] Eyes burn, itch or water [ ] Eye strain [ ] Severe Pain

Do you currently wear glasses? [ ] yes [ ] No

When do you wear glasses?

[ ] All the time [ ] Distance [ ] Reading / near [ ] Computer work

[ ] Other, please explain: _____

Have you ever worn contact lenses? [ ] Yes [ ] No

If no, are you interested in wearing contact lenses? [ ] Yes [ ] No

Do you work at a computer or video display monitor? [ ] Yes [ ] No