

WELCOME TO OUR OFFICE

Today's Date _____
Name _____ Sex: Male Female Date of Birth _____ Age _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ Work # _____ Cell/Mobile # _____
Soc Sec # _____ Referred to us by _____
Employer Name _____ Employer Address _____
Name of Spouse _____ Name of Spouse Employer _____
Emergency Contact: Name _____ Relation _____ Phone # _____
Name of Vision Insurance _____ Group # _____ Member ID# _____
Person Responsible for Payment (Guarantor) _____ Relation to Patient _____
Name of Family Physician _____ Medical Insurance Carrier _____
Email _____

MEDICAL HISTORY

Do you have allergies to medication? No / Yes If yes, explain: _____
List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

Circle any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injury, laser surgery or other (please explain): _____

Are you pregnant and/or nursing? No / Yes
Last eye examination: _____
Do you wear glasses? No / Yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? No / Yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: rigid / soft extended wear / other _____ Are they comfortable? No / Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

Table with 2 columns: DISEASE / CONDITION and RELATIONSHIP TO YOU. Rows include Blindness, Cataract, Crossed Eyes, Glaucoma, Macular Degeneration, Retinal Detachment / Disease, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Lupus, Thyroid Disease, and Other.

REVIEW OF SYSTEMS

CONSTITUTIONAL		EARS, NOSE, MOUTH, THROAT
Fever, Weight Loss / Gain	NO / YES / ?	Allergies / Hay Fever NO / YES / ?
INTEGUMENTARY (Skin)		Sinus Congestion NO / YES / ?
NEUROLOGICAL		Runny Nose NO / YES / ?
Headaches	NO / YES / ?	Post-Nasal Drip NO / YES / ?
Migraines	NO / YES / ?	Chronic Cough NO / YES / ?
Seizures	NO / YES / ?	Dry Throat / Dry Mouth NO / YES / ?
EYES		RESPIRATORY
Dryness	NO / YES / ?	Asthma NO / YES / ?
Redness	NO / YES / ?	Chronic Bronchitis NO / YES / ?
Sandy or Gritty Feeling	NO / YES / ?	Emphysema NO / YES / ?
Burning	NO / YES / ?	VASCULAR / CARDIOVASCULAR
Foreign Body Sensation	NO / YES / ?	Diabetes NO / YES / ?
Excess Tearing / Watering	NO / YES / ?	Heart Pain NO / YES / ?
Mucous Discharge	NO / YES / ?	High Blood Pressure NO / YES / ?
Itching	NO / YES / ?	Vascular Disease NO / YES / ?
Glare / Light Sensitivity	NO / YES / ?	GASTROINTESTINAL
Eye Pain or Soreness	NO / YES / ?	Crohn"s Disease NO / YES / ?
Loss of Vision	NO / YES / ?	Other NO / YES / ?
Blurred Vision	NO / YES / ?	GENITOURINARY
Distorted Vision / Halos	NO / YES / ?	Genitals / Kidney / Bladder NO / YES / ?
Loss of Side Vision	NO / YES / ?	BONES / JOINTS / MUSCLES
Double Vision	NO / YES / ?	Arthritis NO / YES / ?
Chronic Infections	NO / YES / ?	Muscle Pain NO / YES / ?
Sties or Chalazia	NO / YES / ?	Joint Pain NO / YES / ?
Flashes / Spots in Vision	NO / YES / ?	LYMPHATIC / HEMATOLOGIC
Tired Eyes	NO / YES / ?	Anemia NO / YES / ?
ENDOCRINE		Bleeding Problems NO / YES / ?
Thyroid / Other Glands	NO / YES / ?	ALLERGIC / IMMUNOLOGIC NO / YES / ?
		PSYCHIATRIC NO / YES / ?

Do you use a computer regularly? Y / N
 Are you interested in laser vision correction? Y / N
 Are you interested in contact lenses? Y / N

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection of fees, including reasonable attorney fees, and applicable court costs in addition to my outstanding balance. I understand that my insurance company has a contract with me. Should insurance not pay the contracted amount to this office, I understand that my balance is my responsibility. The policy of this office is that payment is expected at the time services are rendered.

Signed _____ Date _____