
## PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone Number _____ Is this a cell number? □ Yes □ No

Work Number: _____ Email _____

Date of Birth _____ Age _____ □ Female □ Male SSN# _____

Employer _____ Occupation _____

## SMALL TALK

When was your last eye exam? _____ Last eye doctor _____

Do you want new **glasses**? □ Yes □ No □ Maybe / Talk to doctor

Do you want to be examined for **contact lenses**? □ Yes □ No □ Maybe / Talk to doctor

*If you wear contacts:* How often do you replace the lenses? _____

Do you sleep in your contacts? □ Yes □ No

Are you interested in **LASIK** (corrective eye surgery?) □ Yes □ No □ Maybe / Talk to doctor

How did you hear about us? □ *I'm a previous patient* □ *Internet search* □ *Insurance provider list*

□ *Passing by* □ *Coworker / Friend / Family – Whom may we thank*? _____

## INSURANCE INFORMATION
***** Skip if not using insurance*****

Patient Relationship To The Insured Sponsor: □ Self □ Spouse □ Dependent Child □ Other

Marital Status (necessary for insurance filing purposes): □ Single □ Married □ Widow

**Insured Sponsor** Last Name _____ First Name _____ MI _____

**Insured Sponsor** Date of Birth _____ □ Female □ Male SSN# _____

***** We will copy your insurance cards at the time of your visit *****

Primary **MEDICAL** Insurance: _____

Secondary **MEDICAL** Insurance: _____

**VISION** Insurance: _____

## YOUR EYE HISTORY

□ Blurred **FAR** vision
□ Blurred **NEAR** vision
□ Dry eyes
□ Burning
□ Itching
□ Foreign body sensation
□ Redness
□ Tearing / Discharge
□ Eye pain
□ Headaches
□ Glare / halos
□ Double vision
□ Tired when reading
□ Lazy eye (amblyopia)
□ Flashes of light
□ Floaters / spots
□ Macular degeneration
□ Glaucoma
□ Cataracts
□ **Other** (list below)

Current or past **eye** conditions/injuries/surgeries _____

## YOUR HEALTH HISTORY

□ ***I do not have any health issues that I am aware of.*** Primary Care Physician _____

**General Health** □ *Fever, sudden weight loss/gain, fatigue* Other _____

**Ears, Nose, Throat** □ *Sinus issues, dry mouth, hearing loss* Other _____

**Respiratory** □ *Asthma, emphysema, shortness of breath* Other _____

**Cardiovascular** □ *Heart disease, **high blood pressure*** Other _____

**Gastrointestinal** □ *Bowel problems, abdominal pain, ulcers* Other _____

**Genitourinary** □ *Urination issues, kidney disease* Other _____

**Blood/Lymph** □ *Blood disorder, **high cholesterol*** Other _____

**Muscles/Bones** □ *Arthritis, joint pain, muscle pain* Other _____

**Skin** □ *Eczema, rosacea, growths* Other _____

**Endocrine** □ *Thyroid disorder, **diabetes*** Other _____

**Neurological** □ *Migraines, multiple sclerosis, depression* Other _____

List other major illnesses, injuries, surgeries _____

Allergies to medications? □ No □ Yes _____ | **Pregnant**? □ No □ Yes

Current medications _____

## FAMILY HISTORY

Please indicate if any member of your family has / had these diseases:

□ Blindness
□ Macular degeneration
□ Heart disease
□ Diabetes
□ High Blood Pressure
□ Glaucoma
□ Retinal Disease
□ Cancer
□ Stroke
□ Other Inherited Disease

## SOCIAL HISTORY

Tobacco use? □ Yes □ No □ Quit _____ years ago | Alcohol use? □ Yes □ No | Drug use? □ Yes □ No

Ever been diagnosed with: □ HIV □ Hepatitis □ Tuberculosis □ Chlamydia □ Gonorrhea □ Syphilis □ N/A