Welcome to our office! It is our desire to provide you with the very best in vision care. We realize your time is valuable and our staff will try to attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (PLEASE PRINT).

Date ___________________________

PATIENT INFORMATION

Patient ____
Last name First name Initial Prefer to be called

Address ____

City ______________________________________ State ______________ Zip ________________

Gender ☐ M ☐ F ☐ Prefer not to answer Marital Status: Married Single Other

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Declined to Specify ☐ European ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ White

Date of Birth ________________ Last 4 of SSN ________________ Email Address __________________

Home Phone ____________________ Work Phone ______________________ Cell Phone ______________

Employer (or school) ______________________________ Occupation (or grade) ____________________

Emergency Contact/Relationship_______________________________ Phone _________________________

Family members who are patients ____

Whom may we thank for referring you to our office? ____

MEDICAL INSURANCE

Plan Name ______________________________ Member ID __________________ Group # ______________

Primary Insurance Holder Name ________________________________ Primary DOB __________________

Primary's Address _____________________________ City__________________ State______ Zip_________

Employer ___________________________________ Work # ____________________________________

VISION INSURANCE

Plan Name ______________________________ Member ID __________________ Group # ______________

Primary Insurance Holder Name _________________________ Primary DOB _________ Primary Last 4 on SSN _____

Primary's Address _____________________________ City__________________ State______ Zip_________

Employer ___________________________________ Work # ____________________________________

EYE HEALTH HISTORY

Date of last exam: ______________________________Doctor: ___________________________________

How many hours per day do you work on a computer? _______ Do you have any other specific visual demands? ___________

Do you currently wear glasses? ☐ Yes ☐ No How old are your glasses? _____ Do you have prescription sunglasses? ☐ Yes ☐ No

Have you ever worn contact lens? ☐ Yes ☐ No If no, are you interested in wearing contact lenses? ☐ Yes ☐ No___

Do you currently wear contacts? ☐ Yes ☐ No Are you interested in refractive surgery (Lasik)? ☐ Yes ☐ No

Describe any problems with your contact lenses: ____

If you are currently experiencing or have been diagnosed with any of the following, please circle all that apply:

Burry distance vision	Frequent headaches	Floaters	Sudden loss of vision	Amblyopia	Glaucoma
Blurry near vision	Itchy eyes	Watery eyes	Dry eyes	Color blindness	Injury
Sensitivity to light	Eye discharge	Double vision	Twitching eyelid	Cataracts	Retinal detachment
Flashing lights	History of styes	Redness	Poor night vision	Crossed eyes	Strabismus

MEDICAL HISTORY

Primary Care Physician ____

Do you have allergies to medications? ☐ Yes ☐ No If yes, please list: ______________________________

Do you have Diabetes? ☐ Yes ☐ No Date of first diagnosis: ______________________________

Do you have Hypertension? ☐ Yes ☐ No Is it controlled? ☐ Yes ☐ No

List any medications that you take: ____

____

List all major injuries, surgeries, and/or hospitalizations you have had (including eye surgeries). ______________________

____

Are you pregnant or nursing? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Do you have any problems with any of the following body systems? (If yes, please circle and explain.)

Gastrointestinal ______________	Nervous ______________	Blood/Lymph ______________
Ear/Nose/Throat ______________	Urinary ______________	Allergies ______________
Cardiovascular ______________	Muscles/Bones ______________	Immunological ______________
Respiratory ______________	Headaches ______________	Integumentary (skin) ______________
High Blood Pressure ______________	Endocrine (glands) ______________	Mental ______________

FAMILY HISTORY

Do you have any of the following that run in your immediate family? (Please circle and list relation.)

High Blood Pressure ______________	Diabetes ______________	Heart Conditions______________
Cancer ______________	Glaucoma ______________	Macular Degeneration ______________
Lazy Eye ______________	Blindness ______________	Retinal Detachment ______________

SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No

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 illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long? ______________________________

Have you been exposed to or infected with: ☐ HIV ☐ Hepatitis