

Welcome to Our Office

(Please Print)

Name _____
 Street _____
 City _____ State _____ Zip _____
 Home phone _____
 Work phone _____
 E-mail address _____
 Social security number _____
 Employer _____
 Occupation _____
 Hobbies _____

Today's date _____ Date of last exam _____
 Date of birth _____ Age _____ Sex: Male Female
 What is the purpose of your visit today? _____

 Spouse (or parent) name _____
 Spouse (or parent) work phone _____
 Medical/Vision Insurance company _____
 Insurance ID # _____
 Do you participate in a flexible spending account? No Yes

How did you hear about our office?

___ Friend or relative. Who? _____
 ___ Another health care practitioner. Who? _____
 ___ Previous patient. Who? _____
 ___ Participation eye care plan. _____
 ___ Yellow pages. Which directory? _____
 ___ Other _____

How will you settle your account today?
 CHECK CASH CREDIT CARD

Personal & Family Medical History

Allergies	No Yes	High Blood pressure	No Yes
Asthma	No Yes	Glaucoma	No Yes
Arthritis	No Yes	Eye diseases	No Yes
Cancer	No Yes	Heart disease	No Yes
Eye surgery	No Yes	Eye injury	No Yes
Diabetes	No Yes		

Current Medications (Rx & Over-the-counter)

Tobacco use	No Yes
Antihistamines	No Yes _____
Diuretics (water pills)	No Yes _____
Blood pressure pills	No Yes _____
Oral Contraceptives	No Yes _____
Oral Hypoglycemics	No Yes _____
Eye Drops	No Yes _____
Others	No Yes _____

Are You currently under the care of a physician?
 No Yes

Name of physician _____
 Physician's phone number _____

Diagnostic Issues

Do you wear glasses or contacts? No Yes
 Please list any complaints about wearing glasses or contacts.

- Do you have more than 1 pair of Rx glasses? No Yes
- Do you work on a computer for long periods? No Yes
- Do you participate in any sports? No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you spend a lot of time outdoors? No Yes
- If you wear bifocals, are you bothered by restricted windows, lines or head tilting? No Yes
- Are there times you'd rather not wear glasses? No Yes
- If you wear contact lenses, are you satisfied with vision and comfort? No Yes
- Are you interested in a risk free trial of the latest in contact lens design(s)? No Yes
- Laser vision correction is a common choice to reduce or eliminate the need of glasses or contacts. Do you desire information and/or a free evaluation regarding your candidacy for laser correction? No Yes

Do You Experience...

Any discomfort with your eyes? No Yes
 Problems with glare or reflection? No Yes
 Sensitivity to light? No Yes
 Headaches? No Yes
 Floaters or flashes of light? No Yes