

PATIENT INFORMATION

Date _____

PLEASE PRINT

Patient Name _____

Nick Name _____

Age _____

Date Of Birth _____

Address _____

City _____

State _____

Zip _____

Home Phone () _____

Business Phone () _____

Ext. _____

Cell Phone () _____

Occupation _____

Employer _____

Student _____

Grade _____

School _____

MEDICARE PATIENTS ONLY - Present Insurance cards to Receptionist

THIS OFFICE DOES NOT SEND STATEMENTS FOR PROFESSIONAL OR OPHTHALMIC SERVICES.

FEEs for professional services are due, payable in full, when rendered. A 50% deposit is required for glasses and contact lenses to be ordered. Remaining balance is due when optical goods are finished for delivery.

This bill will be paid by:

Cash

Check

MasterCard

Visa

Discover

Signed _____

Whom may we thank for referring you to us? _____

HEALTH HISTORY

Please put an "X" in the box by all items that apply to you. "CIRCLE" all items that apply to any family members.

Allergies

Pulmonary Disease

Eye Surgery

Drug Sensitivity

Heart Disease

Eye or Head Injury

Hay Fever

Tuberculosis

Headaches

Asthma

HIV Positive

Cataracts

Skin Condition

Herpes

Macular Degeneration

Fainting/Dizziness

Multiple Sclerosis (MS)

Glaucoma

Diabetes

Autoimmune Syndromes
(i.e. Lupus, Rheumatoid Arthritis)

Other _____

High Blood Pressure

Surgical Operations

High Cholesterol

PLEASE TURN OVER

MEDICAL INFORMATION

Thank you for taking the time to provide us with the following important information. Most health conditions affect your vision, so the more you are able to tell us, the better the eye care that we can provide for you.

1. What is the approximate date of your last eye examination? _____
2. Do you wear glasses now? Yes No When? _____
3. Have you ever worn contacts? Yes No If yes, when were they originally prescribed? _____
4. Do you currently wear contacts? Yes No If no, why did you discontinue? _____

5. How old are your current lenses? Glasses _____ Contacts _____
6. Are you interested in wearing contacts? Yes No When? _____
7. Are you interested in refractive surgery? Yes No (RK, PRK, LASIK)
8. Do you experience any eye strain? Yes No When? _____
9. Do you use a computer? Yes No
10. *Circle any that apply;* eye pain, spots, flashes, floaters, watery eyes, dry eyes, red eyes, itchy eyes, twitch?
11. Please list any hobbies, sports, and recreational activities that you actively engage in: _____

12. What vision needs are important to your job or lifestyle? _____
13. Have you ever received vision therapy (eye exercises)? Yes No
14. Do you have headaches? Yes No When? _____
15. Any injury to head or eyes? Yes No When? _____
16. Any known allergies? Yes No To what? _____
When? _____ How often? _____
17. Are you taking any hormones? (including birth control pills) Yes No
18. List all medications please _____

19. Do you use eye drops? Yes No Type? _____
When? _____
20. Date of last general health exam _____ Doctor: _____
21. Any abnormalities reported? Yes No Explain: _____
22. How is your general health: Good Fair Poor Explain: _____
