

Welcome to our office.

Thank you for choosing our practice for your eye care needs. Please take a moment to complete this form.
If you have any questions or concerns, don't hesitate to ask for assistance.

Patient Information

Date _____

Dr. _____

Mr. _____ Last Name _____ First Name _____ Middle Initial _____

Mrs. _____ Home Address _____ Home Phone (____) _____

Ms. _____ City _____ State _____ Zip _____ Office Phone (____) _____

Cell Phone (____) _____

Date of Birth _____ Occupation _____

Age _____ Employer _____

Eye Color _____ Driver's License Number and State _____

E-Mail _____

Do you prefer to receive calls at Home Work Cell

Whom may we thank for referring you to us? _____

Insurance Information

Do you plan on using vision insurance for payment? Yes No

Name of Insurance _____

Name of plan member _____

Relationship to patient _____

Social Security # of plan member _____ Identification # of patient _____

Vision and Eye Health History

Approximate date of last eye exam _____ Name of Doctor _____

What is your reason for vision care at this time? _____

Have you ever worn contact lenses? Yes / No; Type? Soft / Rigid Gas Permeable / Hard

Are you interested in wearing contact lenses? Yes / No

Do **you** have a history of any of the following?

Glaucoma / Diabetes / Cataracts / Eye Surgery / Eye Injuries / Other

Please Explain: _____

Is there a family history of Glaucoma? Yes / No Which Family Member(s)? _____

Is there a family history of Diabetes? Yes / No Which Family Member(s)? _____

Are you taking any medications for your eyes? Yes / No

Medication

Condition

General Health History

Date of last general medical exam _____ Name of Physician _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

List any medications that you're currently taking and the related conditions.

Medication

Condition

List any allergies to medications: _____

Vision Care

To help us better assist you today, please provide us with the following updated information.

Date _____

Name _____

Address _____

Home Phone _____

Work _____

Cell _____

City/State _____ Zip Code _____

Preferred contact number:

- Home
- Work
- Cell

Email Address _____

What is your Occupation? _____

Are you interested in purchasing glasses or prescription sunglasses today?

- Yes
- No

Are you experiencing any of the following?

- Headaches
- Sensitivity to light
- Poor near vision
- Poor distance vision
- Eye irritation
- Glare (circle all that apply)
 - Computer monitor,
 - Night driving,
 - Florescent lighting,
 - Cell phone,
 - Television

Please rate your eye strain/fatigue on a scale of 1-10, 10 being the worst.

To further assist your needs, please circle the appropriate answer:

- | | | |
|--|----------|----------|
| <input type="checkbox"/> Are you on a computer more than 4 hours per day? | Y | N |
| <input type="checkbox"/> Do you use your near vision more than 4 hours a day? (Texting, reading, etc.) | Y | N |
| <input type="checkbox"/> Do you participate in any water sports? (Fishing, skiing, etc.) | Y | N |
| <input type="checkbox"/> Do any of your recreational hobbies include flying, golfing, hiking, or biking? | Y | N |

Please list any additional comments or changes in medical history, including new medications:

Visual Field Test:

A new computerized instrument now enables us to check for areas of loss of sight in the central (straight ahead) and peripheral (side view) areas. **It can detect early signs of glaucoma, retinal problems, neurological diseases, macular disorders and headache related illnesses.**

We strongly recommend our patients receive this test in addition to their comprehensive visual analysis. The fee for the test is \$35.00.

Would you like to receive this test?

- Yes
- No