Patient Information

Last Name:_____ First Name & Middle Initial:_____

Date:_____ Address: _____
Street **City** **State** **Zip code**

Home Phone:_____ Cell Phone:_____ Patient SSN:_____

Employer (or School):_____ Occupation (or Grade):_____

Birth date: _____ Age:_____ Email:_____

If under 18, please print legal guardian's name and best phone number to contact them in the space below.
_____.

Marital Status: (circle one) Married Single What is the major purpose of this visit? _____

We appreciate you choosing our office for your eye care needs. To better serve you, please answer the following questions:

1. Do/or have you in the past wear/worn eyeglasses or contact lenses?
   Eyeglasses: YES □ NO□ Contact Lenses: YES □ NO □

2. Are you experiencing any eye symptoms? Please circle all that apply:
   Blurred Vision Light Sensitivity Eye Pain/Discomfort Double Vision
   Floaters Flashing Lights Reading Discomfort Red/Burning/Itchy Eyes

3. Do you currently use a computer, tablet, ect.? YES □ NO □ If so, how many hours per day:_____.

4. Have you ever had EYE surgery, disease, or trauma? YES □ NO □ If so, please describe _____
_____

6. Are you currently using any EYE DROPS? YES □ NO □ If so, please list the medications and how often they are used:_____

7. When was your last eye exam?_____ Dr.'s Name:_____

8. When was your last physical examination?_____ Dr.'s Name:_____

9. Have you ever been treated for any medical conditions (diabetes, high blood pressure, etc.)? YES □ NO □
If YES, please explain:_____

_____

10. Are you currently using any medications? YES □ NO □ If so, please list the medications and how often they are used:_____

_____

11. Are you allergic to any medications? YES □ NO □ Please list:_____

Review of Systems:

Do you currently have any of the following problems?

Chronic fever, unexplained weight loss/gain, chronic fatigue……. YES □ ……..……NO □
If YES, please explain:_____

Ear/Nose/Throat problems (i.e. hearing loss, sinus problems)…….YES □ ……..……NO □
If YES, please explain:_____

Heart Problems (i.e. chest pain, irregular heart beat)…….. YES □ ……..……NO □
If YES, please explain:_____

Respiratory Problems (i.e. shortness of breath, chronic cough)……. .YES □ ……..……NO □
If YES, please explain:_____

Gastrointestinal Problems (i.e. heartburn, abdominal pain, prostate cancer)...YES □ ……..……NO □
If YES, please explain:_____

Urinary Problems (i.e. blood in urine, pain)…… YES □ ……..……NO □
If YES, please explain:_____

Skin Problems (i.e. rashes, eczema, new moles or growths)……...… YES □ ……..……NO □
If YES, please explain:_____

Musculoskeletal Problems (i.e. arthritis, osteoporosis)…….…….. YES □ ……..……NO □
If YES, please explain:_____

Neurological Problems (i.e. headaches, seizures, stroke)…… YES □ ……..……NO □
If YES, please explain:_____

Psychiatric Problems (i.e. depression, anxiety)……...…… YES □ ……..……NO □
If YES, please explain:_____

Are you, or could you be pregnant?.....YES □ ……NO □
If YES, how many weeks? _____

Family and Social History:

Do any MEDICAL or EYE diseases run in your family? Please circle and list family member:

□ Glaucoma_____ □ Diabetes_____□High Blood Pressure_____

□ Cataracts_____ □ Cancer_____ □ Macular Degeneration_____

Do you smoke? YES □ NO □ If yes, how much?_____

Do you drink alcohol? YES □ NO □ If yes, how much?_____

Insurance Information

Insurance Company: _____ Insurance Member/Subscriber ID# _____

Primary Holder's Full Name and Date of Birth : _____ DOB: _____
(If you are the patient and the primary holder leave blank)

Primary Holder's Phone number and Address if different than patients:_____

Address: _____
Street **City** **State** **Zip code**