Welcome to Our Office

Date_____ Email Address_____
Patient's Name_____ Age_____ Date of Birth_____ Sex: ❑ M ❑ F
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Race: ❑ White/Caucasian ❑ Black/African American
❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Asian ❑ Some other race ❑ Two or more races
Address_____
Street City State Zip
Telephone (Home) (____)_____(Work) (____)_____(Mobile) (____)_____
Social Security Number_____ Parent's Name (if minor)_____ Spouse's Name_____
If Student, Grade_____ School_____ Occupation _____
Responsible Party for Account_____ Relationship to Patient_____
Payment Preference ❑ Cash ❑ Check ❑ Visa/MC/Discover/AmEx Do you have insurance? ❑ Yes ❑ No
If you have insurance, please list insurance provider_____ I.D. number_____
Who referred you to our office?_____
Who may we contact in case of an emergency?_____ Telephone (___)_____

Eye History/Ocular Review of Systems

Approximate date of last eye examination _____ By Doctor _____
Do you wear glasses? ❑ Yes ❑ No If yes, when were they prescribed?_____
Do you wear contact lenses? ❑ Yes ❑ No If yes, when were they prescribed?_____
Would you like to wear contact lenses? ❑ Yes ❑ No Have you ever worn contact lenses? ❑ Yes ❑ No
Are you interested in refractive surgery (LASIK)? ❑ Yes ❑ No Have you ever received eye exercises? ❑ Yes ❑ No
Do you wear sunglasses? ❑ Yes ❑ No Do you feel your vision problems occur at ❑ Distance ❑ Near ❑ Both ❑ Neither
Do you currently have or have you ever had any of the following problems?

❑ Loss of Vision	❑ Excess Tearing/Watering	❑ Eye Pain
❑ Blurred Vision	❑ Mucous Discharge	❑ Eye Infections
❑ Distorted Vision/Halos	❑ Redness	❑ Eye Injuries
❑ Loss of Side Vision	❑ Itching	❑ Eye Surgery
❑ Double Vision	❑ Burning	❑ Retinal Detachment/Disease
❑ Dry Eyes	❑ Foreign Body Sensation	❑ Cataracts
❑ Floaters in Vision	❑ Sandy or Gritty Feeling	❑ Glaucoma
❑ Flashes of Light in Vision	❑ Eye Strain/Tired Eyes	❑ Macular Degeneration
❑ Twitching Eye Lids	❑ Light Sensitivity/Glare	❑ Crossed Eyes/Lazy Eye
		❑ Keratoconus

Medical History

Are you presently taking any medications (including OTC medications, hormones, supplements, or birth control)? ❑Yes ❑ No
If yes, please list and include dosage_____
_____
Do you have any allergies to medications? ❑ Yes ❑ No If yes, please list _____
List all major injuries, surgeries, and/or hospitalizations you have had_____
_____
Are you pregnant and or nursing? ❑ Yes ❑ No
Approximate date of last general health exam _____Family Physician_____
Address_____ Phone Number (___)_____

Family History

Please note any family history (parents, grandparents, siblings, children, aunts, uncles) for the following conditions:

Condition	Yes	No	?	Relationship to You
Blindness	❑	❑	❑	_____
Cataracts	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Crossed Eyes/Lazy Eye	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Keratoconus	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Rheumatoid Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____

Please turn this sheet over and complete the other side.

Review of Systems

Do you currently or have you ever had any problems in the following areas?

System	Yes	No	?
Constitutional (fever, weight loss, gain)	❑	❑	❑
Integumentary (skin)	❑	❑	❑
Neurological			
Headaches/Migraines	❑	❑	❑
Seizures	❑	❑	❑
Multiple Sclerosis	❑	❑	❑
Ears, Nose, Mouth, Throat			
Allergies, Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
Cancer	❑	❑	❑
Respiratory			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Psychiatric	❑	❑	❑
Allergic/Immunologic	❑	❑	❑
Endocrine (thyroid/other glands)	❑	❑	❑

	Yes	No	?
Vascular/Cardiovascular			
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
Heart Attack	❑	❑	❑
Stroke	❑	❑	❑
Heart Disease/Pain	❑	❑	❑
High Cholesterol	❑	❑	❑
Gastrointestinal			
Constipation	❑	❑	❑
Diarrhea	❑	❑	❑
Ulcers	❑	❑	❑
Acid Reflux	❑	❑	❑
Genitourinary (genitals/kidney/bladder)	❑	❑	❑
Bones/Joints/Muscles			
Rheumatoid Arthritis	❑	❑	❑
Osteoarthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
Lymphatic/Hematologic			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss this information with the doctor.

Employer_____ Address_____

Are you: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Do you use a computer or a tablet? ❑Yes ❑ No

Do you drive? ❑ Yes ❑ No

What are some of your hobbies?_____

Do you smoke? ❑ Yes ❑ No If yes, type/amount/how long:_____

Have you ever smoked? ❑ Yes ❑ No If yes, type/amount/how long:_____

Do you use other 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 ever been exposed to/infected with any of the following? ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑None

Authorization

I certify that the above questions have been accurately answered to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and the records of any treatment given to me or my dependents to third party payers and/or health practitioners. If applicable, I authorize my insurance company to pay directly to the doctor insurance benefits on my behalf. I understand that my insurance carrier may pay less than the actual bill for services and may not cover some tests or procedures. I understand that in order to receive a prescription for eyeglasses, a refraction must be performed and there is a charge for it. I understand that in order to receive a prescription for contact lenses, a refraction and a contact lens fitting or evaluation must be performed and there is a charge for them. If I am unsure as to what my insurance covers, I will ask the office staff for an explanation prior to receiving any services. I agree to be ultimately responsible for payment of services rendered to me or my dependents.

_____ _____

Signature of Patient (or parent if minor) Date

_____O.D. _____

Doctor's Signature Date