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*Our vision is to protect yours*

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home / Mobile Phone: \_\_\_\_\_ Texting Okay? Y / N Work Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Male / Female SS#: \_\_\_\_\_

Marital Status:  Single  Married  Other \_\_\_\_\_ Race: Asian / Black / Hispanic / White / Other \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Who is the insurance policy holder?

Self  Other: Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's SSN: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Name of Primary **Medical** Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

Name of Secondary **Medical** Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

Name of **Vision** Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

✦ *If you have **diabetes**, your exam will be billed to your **medical** insurance. Every diabetic exam requires dilation and a report will be sent to your medical provider. Please note that the specialist copay is typically between \$30-\$60*

### Eye History

Why did you schedule your visit today? \_\_\_\_\_

Do you wear glasses? Yes / No / Full-time / Part-time / Distance Only / Near Only

Do you currently wear contacts? Yes / No / Clear / Color Brand \_\_\_\_\_

Do you want to be fitted for contacts today? Yes / No / Clear / Color

#### *Please check any of the following that apply*

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Blurry Distance Vision | <input type="checkbox"/> Itchy Eyes        | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Blurry Near Vision     | <input type="checkbox"/> Dry Eyes          | <input type="checkbox"/> Poor Night Vision    | <input type="checkbox"/> Cataracts            |
| <input type="checkbox"/> Double Vision          | <input type="checkbox"/> Red Eyes          | <input type="checkbox"/> Loss of Vision       | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Eye Strain             | <input type="checkbox"/> Watery Eyes       | <input type="checkbox"/> Crossed Eyes         | <input type="checkbox"/> Retinal Disease      |
| <input type="checkbox"/> Eye Infection          | <input type="checkbox"/> Wandering Eye     | <input type="checkbox"/> Light Sensitive      | <input type="checkbox"/> Blindness            |
| <input type="checkbox"/> Eye Pain / Soreness    | <input type="checkbox"/> Mucous Discharge  | <input type="checkbox"/> Sandy/Gritty Feeling | <input type="checkbox"/> Prosthetic Eye       |
| <input type="checkbox"/> Tired Eyes             | <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Poor Color Vision    |   |
| <input type="checkbox"/> Burning Eyes           | <input type="checkbox"/> See Flashes       | <input type="checkbox"/> Droopy Lid           | <input type="checkbox"/> None                 |

*Please complete other side*

Patient Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ Where did you get your last exam? \_\_\_\_\_

Date of Last Physical/Medical Exam: \_\_\_\_\_ Name of Medical doctor: \_\_\_\_\_

### Personal Medical History (Review of Systems)

**Cardiovascular:**  None

- Hypertension
- Stroke
- Heart Disease
- Vascular Disease
- Other \_\_\_\_\_

**Endocrine:**  None

- Non-Insulin Dependent Diabetes
- Insulin Dependent Diabetes
- Thyroid Problem
- Hormonal Dysfunction
- Other \_\_\_\_\_

**Respiratory:**  None

- Asthma
- Bronchitis
- Emphysema
- COPD
- Other \_\_\_\_\_

**Constitutional:**  None

- Weight loss/gain
- Fatigue
- Blackouts
- Other \_\_\_\_\_

**Psychiatric:**  None

- ADHD
- Depression
- Schizophrenia
- Other \_\_\_\_\_

**Ear/Nose/Throat:**  None

- Hearing Loss
- Upper Respiratory Infection
- Sinus Infection
- Other \_\_\_\_\_

**Neurological:**  None

- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Other \_\_\_\_\_

**Musculoskeletal:**  None

- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Other \_\_\_\_\_

**Immunologic:**  None

- AIDS or HIV
- Rheumatoid Arthritis
- Lupus
- Neurofibromatosis
- Other \_\_\_\_\_

**Hematological:**  None

- Anemia
- Leukemia
- Sickle Cell Disease
- Other \_\_\_\_\_

**Gastrointestinal:**  None

- Chron's
- Colitis
- Acid Reflux
- Other \_\_\_\_\_

**Dermatologic:**  None

- Eczema
- Rosacea
- Psoriasis
- Other \_\_\_\_\_

**Genitourinary:**  None

- Bladder Infections
- Sexually Transmitted Disease
- Other \_\_\_\_\_

**Tobacco Products:**  Never Smoked

- Former Smoker
- Current daily smoker
- Current occasional smoker

**Alcohol Use:**  None

- Social Use
- Daily Use
- Dependency

Medication Allergies: \_\_\_\_\_ Other Allergies: \_\_\_\_\_

Please list all medications currently taken: \_\_\_\_\_

Please list any major surgeries: \_\_\_\_\_

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

### Family History

Disease/Condition	Relationship	Disease/Condition	Relationship
Glaucoma:	Yes/No _____	High Blood Pressure:	Yes/No _____
Macular Degeneration:	Yes/No _____	Diabetes:	Yes/No _____
Retinal Detachment:	Yes/No _____	Cancer:	Yes/No _____
Blindness:	Yes/No _____	Heart Disease:	Yes/No _____
Crossed Eyes:	Yes/No _____	Thyroid Disease:	Yes/No _____

