WELCOME BACK TO OUR OFFICE

fields marked with an "*" are required

Name *

Today's Date mm/dd/yyyy

Spouse or Parent *

Mailing Address *

City *

State/Province * Zip/Postal Code *

Date of Birth mm/dd/yyyy *

Age *

Sex:
- Male
- Female

Home Phone xxx-xxx-xxxx *

Work Phone xxx-xxx-xxxx *

Social Security # xxx-xx-xxxx *

Email Address

(for patient communication only)

MEDICAL HISTORY

- Allergies
- Arthritis
- Heart Disease
- Asthma
- Cancer
- Skin Disorder
- Diabetes
- Cataracts
- High Blood Pressure
- Eye Injury
- Eye Surgery
- Glaucoma
- Nerves
- Kidney Problems
- Other

CURRENT MEDICATIONS (Rx or over the counter)

Medication Name

- Antihistamines
- Blood Pressure Pills
- Diuretic (water pill)
- Oral Contraceptives
- Sleeping Tablets
- Eye Drops
- Others
- Allergies to Medications

Date of Last Eye Exam xx/xx/xxxx

Name of Last Eye Doctor

Date of Last Physical Exam xx/xx/xxxx

Name of Physician

FAMILY MEDICAL HISTORY

	Relationship to you
☐ Blindness	
☐ Glaucoma	
☐ Diabetes	
☐ High Cholesterol	
☐ Other	

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.
This information is important for medical purposes as well as compliance with insurance directives.

Would prefer to discuss your Social History information with your doctor?

☐ Yes ☐ No

Do you use tobacco products?

☐ YES ☐ NO

Do you drink alcohol?

☐ YES ☐ NO

Employer (or School)

Occupation (or Grade)

What is the major purpose of this visit?

Any problems with your present contact lenses or glasses?

Vision Insurance

How will you settle your account?

☐ Check ☐ Financing ☐ Credit Card ☐ Insurance ☐ Cash

Do you experience.....(check those that apply)

☐ Burning	☐ Uncomfortable Glasses
☐ Itchiness	☐ Sudden loss of vision
☐ Nausea	☐ Sensitivity to light
☐ Watery Eyes	☐ Fainting or dizziness
☐ Double Vision	☐ Blurry distance vision
☐ Flashes of Light	☐ Blurry near vision
☐ Glare or Reflection	☐ Gritty feeling in eyes
☐ Soreness	☐ Objects floating in vision
☐ Eye Strain	☐ Trouble seeing at night
☐ Headaches	☐ Dryness
☐ Redness	☐ Other

VISUAL NEEDS

Do You.....(check the box if your answer is yes)

- ☐ Work on a computer for long periods of time?
- ☐ Have only one pair of glasses?
- ☐ Want information on thinner, lighter lenses?
- ☐ Wear bifocals?
- ☐ Want information on "no line" bifocals?
- ☐ Prefer not to wear your glasses at times?
- ☐ Spend a lot of time outdoors?
- ☐ Ever find a need for prescription sunglasses?
- ☐ Have problems with glare or reflections (ex: night driving)?
- ☐ Do work requiring safety glasses?
- ☐ Participate in sports? What?
- ☐ Want more information about corrective vision surgery?
- ☐ Wear or ever tried wearing contacts?

What kind?