WELCOME TO OUR OFFICE

Please Print

Last Name_____ First _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Cell Phone _____

E-mail _____ Preferred Contact Method: email / cell / home / work

D.O.B. _____ Age _____ Sex: M / F Social Security #_____-____-_____ Occupation_____

Insurance Co._____ Member ID _____Gr.#_____

How did you hear about us? Location ◆ Newspaper ◆ Ins. Co. ◆ Friend/Relative ◆ and their name _____

Approximate date of last exam _____ Name of your previous Eyecare Physician _____

Do you currently wear glasses? Yes ◆ No ◆ Contact Lenses? Yes ◆ No ◆

Your Reasons for Visiting Our Office Today: (Please check all that apply)

VISION Reasons	**MEDICAL Eye Problems**	
◆ No Complaints	◆ Blurred far vision	◆ Eye Pain
◆ Consultation for Refractive Surgery	◆ Blurred near vision	◆ See spots or light flashes
◆ Want Contact Lenses	◆ Eyes feel tired	◆ Discharge or watery eyes
◆ Want new eyeglasses	◆ Eyes feel dry	◆ Stye or chalazion
	◆ Glare / light sensitive	◆ Headaches
	◆ Eyes red	◆ Eyes burn
		◆ Previous eye disorder check-up

Your General Health and Family History (Past or Present)

Please check all relevant items for you by *circling* the item or *checking (√)* it for a blood relative.

Allergic/Immunologic
None__
◆ drug allergy
◆ environmental allergy
◆ rheumatoid arthritis
◆ lupus

Ears, Nose, & Throat
None__
◆ Upper Resp. Tract Infect
◆ Cold sores - Herpes
◆ Sinusitis

Gastrointestinal
None.__
◆ Crohn's
◆ colitis
◆ ulcer
◆ digestive

Integumentary
None__
◆ eczema
◆ rosacea
◆ psoriasis

Psychiatric
None__
◆ depression
◆ panic disorder
◆ schizophrenia
◆ dementia

Cardiovascular
None__
◆ heart disease
◆ hypertension
◆ stroke
◆ vascular disease

Endocrine
None___
◆ non-insulin dependent diabetes
◆ insulin-dependent diabetes
◆ thyroid dysfunction
◆ hormonal dysfunction

Genitourinary
None__
◆ STD - herpes, chlamydia
◆ Kidney or bladder disorders

Muskuloskeletal
None__
◆ fibromyalgia
◆ muscular dystrophy
◆ osteoarthritis
◆ ankylosing spondylitis

Respiratory
None__
◆ cigarette smoker
◆ asthma
◆ bronchitis
◆ emphysema
◆ hormonal dysfunction
◆ COPD

Constitutional
None__
◆ developmental disability
◆ weight loss
◆ fever
◆ fatigue
◆ trauma

Eyes
None__
◆ glaucoma
◆ cataracts
◆ macular degeneration
◆ surgery
◆ inflammatory disorders

Hematologic/Lymphatic
None__
◆ anemia
◆ large volume blood loss
◆ leukemia

Neurological
None__
◆ multiple sclerosis
◆ epilepsy

Cancer
◆ Specify Type:
_____
When diagnosed ◆ surgery
_____

Your current medications and for what condition:_____

Any Known Drug Allergies:_____

Social History

Do you use tobacco products? ◆No ◆Yes If yes, type/amount/how long _____

Do you drink alcohol? ◆No ◆Yes If yes, type/amount/how long _____

Do you use illegal drugs? ◆No ◆Yes If yes, type/amount/how long _____

Approximately how many hours per day do you use a computer? _____

Your hobbies and special visual needs: _____

THANK YOU FOR THE PRIVILEGE OF ALLOWING US TO CARE FOR YOU.