Patient Information

Last Name:_____ First Name:_____ M.I.:___

Address:_____ City:_____ State:____ Zip:_____

D.O.B. ___/___/_____ Gender: M – F SSN:___-___-____

Home Phone: _____ Work Phone:_____ Cell:_____

Parent/Guardian/Spouse:_____ Alt. Contact Phone:_____

Email:_____

Family Doctor: _____ Last Medical Exam: _____

Occupation:_____ Sports/Hobbies:_____

Last Eye Exam:_____ Previous Optometrist:_____

Drivers License #:_____

State D.L .issued from:_____

Medical History:

Allergic to Medication: Yes / No If so, list:_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____ ___

List all major injuries, surgeries and/or hospitalizations you have had:

_____

Circle Any of the following you have had:

Prominent eyes: Yes / No	Crossed Eyes: Yes / No	Lazy Eye: Yes / No
Eye Infection: Yes / No	Retinal Disease: Yes / No	Glaucoma: Yes / No
Cataracts: Yes / No	Eye Injury: Yes / No	Drooping Eyes: Yes / No

Are you pregnant? Yes /No

Do you wear glasses Yes / No If yes, how old is your present pair of lenses:_____

Do you wear contacts? Yes / No If yes, how old is your present pair of lenses:_____

Type of Contact Lenses: Rigid / Soft Are they Comfortable? Yes / No

How many nights a week do you sleep in your contacts?:_____

Hours of Computer Usage per week: 10 or under / 10-20 / 20-30 / 30-40/ over 40

Family History:

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions.

DISEASE/CONDITION		**Relationship**
Blindness	Yes / No	_____
Cataract	Yes / No	_____
Glaucoma	Yes / No	_____
Crossed Eyes	Yes / No	_____
Macular Degeneration	Yes / No	_____
Retinal Detachment / Disease	Yes / No	_____
Arthritis	Yes / No	_____
Cancer	Yes / No	_____
Diabetes	Yes / No	_____
Heart Disease	Yes / No	_____
High Blood Pressure	Yes / No	_____
High Cholesterol	Yes / No	_____
Kidney Disease	Yes / No	_____
Lupus	Yes / No	_____
Thyroid Disease	Yes / No	_____
Other		Explain:_____

Social History

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

I WOULD PREFER TO DISCUSS MY SOCIAL HISTORY WITH MY DOCTOR DIRECTLY.
Yes / No

Do you drive? Yes / No If yes, do you have any visual difficulty when driving ?Yes No
If yes, please describe_____

Do you use:

Tobacco products? Yes / No If yes, type / amount / how long?_____
Alcohol? Yes / No If yes, type / amount / how long?_____
Illegal drugs? Yes / No If yes, type / amount / how long?_____

Have you ever been exposed to or infected with:

Gonorrhea	Yes / No	Hepatitis	Yes / No
Syphilis	Yes / No	HIV/AIDS	Yes / No

Review of Systems

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

CONSTITUTIONAL

Fever	Yes / No
Weight Gain/Loss	Yes / No

INTEGUMENTARY

Skin	Yes / No

NEUROLOGICAL

Headaches	Yes / No
Migraines	Yes / No
Seizures	Yes / No

EYES

Loss of Vision	Yes / No
Blurred Vision	Yes / No
Distorted Vision / Halos	Yes / No
Loss of Side Vision	Yes / No
Double Vision	Yes / No
Dryness	Yes / No
Mucous Discharge	Yes / No
Redness	Yes / No
Itching	Yes / No
Burning	Yes / No
Foreign Body Sensation	Yes / No
Excess Tearing	Yes / No
Glare / Light sensitivity	Yes / No
Eye Pain or Soreness	Yes / No
Chronic Infection of the Eye or Lid	Yes / No
Sties or Chalazion	Yes / No
Flashers	Yes / No
Floaters in Vision	Yes / No
Tired eyes	Yes / No

LYMHATIC / HEMATOLOGICAL

Anemia	Yes / No
Bleeding Problems	Yes / No

ALLERGIC, IMMUNOLOGIC **Yes / No**

PSYCHIATRIC Yes / No

EARS, NOSE THROAT AND MOUTH

Allergies / Hay Fever	Yes / No
Sinus Congestion	Yes /No
Runny Nose	Yes / No
Post-Nasal Drip	Yes / No
Chronic Cough	Yes / No
Dry Throat / Mouth	Yes / No

RESPIRATORY

Asthma	Yes / No
Chronic Bronchitis	Yes / No
Emphysema	Yes / No

VASCULAR, CARDIOVASCULAR

Diabetes	Yes / No
Heart Pain	Yes / No
High Blood Pressure	Yes / No
High Cholesterol	Yes / No

GASTROINTESTINAL

Diarrhea	Yes / No
Constipation	Yes / No

GENITOURINARY

Gonads / Kidneys / Bladder	Yes / No

BONES /JOINTS/ MUSCLES

Arthritis	Yes / No
Muscle Pain	Yes / No
Joint Pain	Yes / No

If you answered yes to any of the above or have a condition not listed, please explain.

_____
_____
_____

INSURANCE INFORMATION

Name of Insurance:_____

Primary Member Name:_____

Primary I.D.#:_____

Group Member:_____

Policy Holder:_____

Primary Holder SSN:_____

Secondary Insurance?_____

When filing insurance, patient is responsible for any balance the insurance does not cover.

By signing below, I agree all information above is true and correct.

Patient/Guardian Signature: _____Date:_____

FOR OFFICE USE ONLY!_____

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OD)_____
OS)_____

TONO PEN
OD)_____
OS)_____

AK
OD)_____
OS)_____

SPEC
OD)_____
OS)_____

ORDER CONTACT TRIALS? _____

FILED INSURANCE?_____