WELCOME TO OUR OFFICE - Please fully complete or correct the following information

Patient's Name: _____ Today's Date: _____
Address: _____
Home Phone: _____
Day Phone: _____
Cell Phone: _____
Preferred Contact Method: (please circle one) Home Phone Cell Phone Day Phone Email
Patient's SSN : _____
Patient's Birth Date: _____
Sex: M F Marital Status: S M D W Race: White Black Asian Hispanic
Patient's Employer: _____
Patient's Occupation: _____
Email Address: _____
Guarantor: _____
Emergency Contact & Phone: _____
If this is your first visit, who may we thank for referring you? _____

PATIENT MEDICAL HISTORY

The information in this confidential case history form is critical to the evaluation of your vision and health.

Name of Family Physician _____
Date of last Physical Exam _____

Allergies to Medications: ( )Yes (list below) ( )No

_____

CURRENT MEDICATIONS (ALL prescription and over the counter)
If you have a list, give to the front desk to copy and skip this section

_____
_____
_____

Preferred Pharmacy/City: _____

Review of Symptoms: Are you now or have you ever been treated for any of the following conditions?

( ) Diabetes ( ) Asthma
( ) Heart Disease ( ) Allergies
( ) High Blood Pressure ( ) Arthritis
( ) Cholesterol ( ) Thyroid
( ) Nerves ( ) Kidney
( ) Cancer ( ) Skin
( ) Psychiatric ( ) Ear, Nose Throat
( ) Fever, weight gain/loss ( ) Headaches/Migraines
( ) Sleep Apnea ( ) None of the above

PATIENT EYE HISTORY

Date of last eye exam (if elsewhere): _____
How old is your current pair of glasses? _____
Are you interested in LASIK laser vision correction? _____

Do you currently wear contact lenses? ( ) Yes ( ) No
If yes, are you satisfied with the vision and comfort?( )Y ( )N
If no, are you interested in trying contact lenses? ( )Y ( )N

Have you ever been diagnosed/treated for the following?

( ) Cataracts ( ) Glaucoma ( ) Macular Degeneration ( ) Retinal Detachment
( ) Iritis/Uveitis ( ) Lazy Eye ( ) Eye Injury ( ) None of the above ( ) Other_____

Do you experience or have you ever experienced?

( ) Blurry Vision ( ) Burning/stinging ( ) Sunlight Sensitivity ( ) Tearing ( ) Grittiness
( ) Trouble seeing at night( ) Double Vision ( ) Flashes/Floater/Spots ( ) Crossed eye/eye turn ( ) None of the above
( ) Other_____

SOCIAL HISTORY

Please list any interests or hobbies _____
Do you use tobacco? _____ if yes, type: cigarettes/cigars or smokeless Do you use illegal drugs?_____
Do you drink alcohol? _____ if yes, type/amount:_____
Have you ever been exposed to or infected with: Gonorrhea / Hepatitis / HIV / Syphilis or ( ) discuss directly with the doctor

FAMILY EYE & MEDICAL HISTORY

Is there a family medical history of any of the following? (Check all that apply)

( ) Blindness ( ) Cataracts ( ) Macular degeneration ( ) Glaucoma
( ) Lazy Eye ( ) Corneal Problems ( ) Retinal Problems ( ) None of the above
( ) Diabetes ( ) Heart Disease ( ) High blood pressure ( ) Other _____