WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Date _____

Patient's Full Legal Name _____

DOB _____/_____/_____ SSN# _____/_____/_____

Address _____

Apt._____

City _____St_____ Zip _____

Home Phone_____

Cell Phone_____

Work Phone _____

Email _____

Pharmacy_____

How did you hear about us?_____

Marital Status ❑ M ❑ S ❑ D ❑ W

Spouses Name _____

DOB _____/_____/_____ SSN# _____/_____/_____

Primary Language ❑ English ❑ Spanish ❑ Other

Race ❑ White ❑ African American ❑ Asian

❑ Other _____ ❑ Decline to Answer

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino

❑ Unknown ❑ Decline to Answer

Employer_____Occupation_____

Last PCP Visit_____ Doctor_____

Last eye exam_____Where_____

Miscellaneous

List any previous surgeries with dates

_____

_____

_____

Are You Pregnant? ❑ Yes ❑ No

Are You Breastfeeding? ❑ Yes ❑ No

Hobbies/Recreation_____

_____

_____

How many hours per day do you use computer? _____

Do you wear glasses? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in refractive surgery? ❑ Yes ❑ No

Do you perform fine or close-up work? ❑ Yes ❑ No

Are you outdoors all or part of the time? ❑ Yes ❑ No

Do you have trouble reading signs when driving at night? ❑ Yes ❑ No

Are you bothered by glare from: Overhead lighting? ❑ Yes ❑ No

A computer screen? ❑ Yes ❑ No

Oncoming headlights at night? ❑ Yes ❑ No

Are you sensitive in bright sunlight? ❑ Yes ❑ No

Ocular History

(mark yes or no to each question)

Age-related macular degeneration ❑ Yes ❑ No

Amblyopia (Lazy eye) ❑ Yes ❑ No

Blindness-one eye ❑ Yes ❑ No

Bindness-both eyes ❑ Yes ❑ No

Cataracts ❑ Yes ❑No

Glaucoma ❑ Yes ❑ No

Injury to the eye region ❑ Yes ❑ No

Keratoconus ❑ Yes ❑ No

Retinopathy ❑ Yes ❑ No

Strabismus (Crossed eyes) ❑ Yes ❑ No

Tear film insufficiency (dry eyes) ❑ Yes ❑ No

Other

_____

_____

Patient's Past Medical History

(mark yes or no to each question)

HIV/ AIDS	❑ Yes ❑ No		
Arthritis	❑ Yes ❑ No	Hypercholesterolemia (high cholesterol)	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Hypertensive disorder (Hypertension)	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	Seasonal allergy	❑ Yes ❑ No
(COPD)	❑ Yes ❑ No	Thyroid dysfunction	❑ Yes ❑ No
Diabetes mellitus	❑ Yes ❑ No	Mental disorder	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Rheumatoid arthritis	❑ Yes ❑ No
Heart disease	❑ Yes ❑ No		

Family Health History

(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

Amblyopia (Lazy eye)	❑ Yes ❑ No _____	Strabismus (cross eyes)	❑ Yes ❑ No _____
Blindness and/or vision impairment	❑ Yes ❑ No _____	Arthritis	❑ Yes ❑ No _____
Cataract	❑ Yes ❑ No _____	Cancer	❑ Yes ❑ No _____
Macular Degeneration	❑ Yes ❑ No _____	Diabetes mellitus	❑ Yes ❑ No _____
Glaucoma	❑ Yes ❑ No _____	Cardiovascular disease	❑ Yes ❑ No _____
Hypertension (high blood pressure)	❑ Yes ❑ No _____	Stroke	❑ Yes ❑ No _____
Retinal disorder	❑ Yes ❑ No _____		

Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

_____

_____

_____

_____

❑ No Medications

Medication Allergies

List any allergies you may have and reaction.

_____

_____

_____

_____

❑ No Medication Allergies