WELCOME TO OUR OFFICE

Today's Date_____
Last_____First_____MI____
Address_____
City_____St._____Zip_____
Home Phone_____
Cell_____Work_____
Employer (or School)_____
Occupation_____
Date of Birth_____Age_____Sex____
Email_____
What is the purpose of this visit?
_____
Any problems with your present contacts or glasses?
_____
Who may we thank for referring you to our office?
_____

Patient Eye History

Date of Last Eye Exam_____
By Whom_____
Solutions used_____
Do you…(Check the box if the answer is yes)

- ☐ Wear contact lenses?
- ☐ Interested in contact lenses?
- ☐ Sleep in your contact lenses?
- ☐ Wear glasses?
- ☐ Want a new pair of updated glasses?
- ☐ Want prescription sunglasses?
- ☐ Want to renew your contact lens prescription?
- ☐ Recommended eye exam for children is 3 years old!
- ☐ Have family members in need of eye care?
- ☐ Want information on Laser Vision correction surgery?

Preferred contact method (check box)
☐**postal** ☐ **email** ☐ **Text** ☐ **other**_____
Language: ☐ **English** ☐**Spanish** ☐**other**_____
Race: ☐**Native American** ☐**Asian** ☐**African-American** ☐**Hispanic** ☐ **Caucasian**
Ethnicity: ☐**Hispanic** ☐**Native Hawaiian/Pacific Islander** ☐**Not Hispanic**
Do you smoke**?** ☐**Yes** ☐**Never have** ☐**Quit**_____
Height**:**_____ Weight_____
Do you experience or have you ever experienced?
☐Blurry vision ☐Burning ☐sunlight sensitivity
☐Floaters/spots ☐Tearing ☐ crossed eye/eye turn
☐Grittiness ☐Headaches ☐Trouble seeing at night
☐Itchiness ☐Double Vision ☐Occasional dryness
☐Flash of light

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

Patient Medical History

Name of Family Physician_____
City_____
Date of Last Physical Check-Up_____
CURRENT MEDICATIONS(Rx or Over the Counter)
List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
_____
_____
Allergies to Medications: Y N
Please list:_____
_____
Have you ever been diagnosed or treated for the Following? Y or N if yes check boxes
☐ Allergies ☐Diabetes ☐High blood pressure
☐Asthma ☐Thyroid ☐Other_____
☐Arthritis ☐Heart Disease _____
☐Cancer ☐Kidney _____
☐Cholesterol☐Anxiety/Depression

Family Medical/Eye History (Check all that apply)

	You	**Family**	**Relationship**
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Corneal Problems	☐	☐	_____
Glaucoma	☐	☐	_____
Lazy Eye	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Problems	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Iritis/Uveitis	☐	☐	_____
Eye Injury	☐	☐	_____
Other eye Disorders	☐	☐	_____

Have you had prior ocular surgeries? If yes please list
_____
_____

Insurance Information:

Vision Insurance_____
Subscriber Name_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber Birth Date_____
Is this a high deductible insurance plan? ☐ Y ☐ N