

**General Information:**

**Appointment Date:** \_\_\_/\_\_\_/\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Gender: M F SSN: \_\_\_-\_\_\_-\_\_\_ Occupation/Grade: \_\_\_\_\_ Employer/School: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Email: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_  
Emergency Contact Phone: ( ) \_\_\_\_\_ Marital Status: Single / Married / Divorced / Widowed  
**How did you find out about our office / Who referred you to our office?** \_\_\_\_\_

**Case History / Reason for Visit:**

Date of Last Medical Exam: \_\_\_/\_\_\_/\_\_\_ Primary Care Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Date of Last Eye Exam: \_\_\_/\_\_\_/\_\_\_ Eye Doctor's Name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Do you wear: Glasses / Contact Lenses / Both Used for: Distance / Reading / Full-time / Occasionally / Driving only  
How old are your current glasses? \_\_\_\_\_ How old are your current contact lenses? \_\_\_\_\_  
How many hours per day do you wear your contact lenses? \_\_\_\_\_ Do you sleep in your contact lenses? \_\_\_\_\_  
Contact lens solution used: \_\_\_\_\_ How often do you replace your contact lenses? \_\_\_\_\_

**Vision Complaints & Ocular History (circle any that apply):**

Are you having problems seeing with your glasses/contacts? Yes / No Which Eye? Right / Left / Both  
Where are the problems? Distance / Near / Computer How long have you noticed this problem? \_\_\_\_\_  
Severity: Mild / Moderate / Severe How often does this problem occur? Constantly / Occasionally / Rarely  
How did it begin? Gradually / Suddenly

**List SYSTEMIC & OCULAR MEDICATIONS you are taking:**

\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
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\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_

**FAMILY Health History: (circle all that apply)**

**Ocular:** Glaucoma Cataracts Macular Degeneration  
Blindness Retinal Detachment Eye Turns  
Other: \_\_\_\_\_

**Medical:** Hypertension Heart Disease Cholesterol  
Diabetes Cancer Stroke Lupus  
Other: \_\_\_\_\_

**List all drug/medication ALLERGIES you know of:**

\_\_\_\_\_ What happens? \_\_\_\_\_  
\_\_\_\_\_ What happens? \_\_\_\_\_  
\_\_\_\_\_ What happens? \_\_\_\_\_

**Social History:**

Do you drive? Y / N  
Are you a smoker? Y / N If yes, how much? \_\_\_\_\_  
Have you smoked in the past? Y / N  
If yes, when did you quit? \_\_\_\_\_  
Do you drink alcohol?  
Y / N If yes, how much? \_\_\_\_\_  
Have you ever been diagnosed with an STD?  
Y / N If yes, which one? \_\_\_\_\_  
Are you pregnant? Y / N Nursing? Y / N

**Patient Medical History Information: (please indicate if YOU have or have ever had any of the following conditions)**

<p><b><u>Allergic/Immunologic</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Drug Allergy  <input type="checkbox"/> <input type="checkbox"/> Environmental Allergy  <input type="checkbox"/> <input type="checkbox"/> Seasonal Allergy  <input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis  <input type="checkbox"/> <input type="checkbox"/> Lupus  <input type="checkbox"/> Other:</p>	<p><b><u>Endocrine</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Diabetes, Type 1  <input type="checkbox"/> <input type="checkbox"/> Diabetes, Type 2  <input type="checkbox"/> <input type="checkbox"/> Thyroid dysfunction  <input type="checkbox"/> <input type="checkbox"/> Hormonal dysfunction  <input type="checkbox"/> Other:</p>	<p><b><u>Gastrointestinal</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Crohn's  <input type="checkbox"/> <input type="checkbox"/> Colitis  <input type="checkbox"/> <input type="checkbox"/> Ulcer  <input type="checkbox"/> <input type="checkbox"/> Acid Reflux  <input type="checkbox"/> Other:</p>	<p><b><u>Musculoskeletal</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Fibromyalgia  <input type="checkbox"/> <input type="checkbox"/> Muscular dystrophy  <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis  <input type="checkbox"/> <input type="checkbox"/> Ankylosing spondylitis  <input type="checkbox"/> Other:</p>	<p><b><u>Respiratory</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Asthma  <input type="checkbox"/> <input type="checkbox"/> Bronchitis  <input type="checkbox"/> <input type="checkbox"/> Emphysema  <input type="checkbox"/> <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> Other:</p>
<p><b><u>Cardiovascular</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Heart Disease  <input type="checkbox"/> <input type="checkbox"/> Hypertension  <input type="checkbox"/> <input type="checkbox"/> Stroke  <input type="checkbox"/> <input type="checkbox"/> Vascular Disease  <input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol  <input type="checkbox"/> Other:</p>	<p><b><u>Constitutional</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Weight loss  <input type="checkbox"/> <input type="checkbox"/> Developmental Disability  <input type="checkbox"/> <input type="checkbox"/> Fever  <input type="checkbox"/> <input type="checkbox"/> Fatigue  <input type="checkbox"/> <input type="checkbox"/> Trauma  <input type="checkbox"/> Other:</p>	<p><b><u>Psychiatric</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Depression  <input type="checkbox"/> <input type="checkbox"/> Panic Disorder  <input type="checkbox"/> <input type="checkbox"/> Schizophrenia  <input type="checkbox"/> <input type="checkbox"/> Bipolar disorder  <input type="checkbox"/> Other:</p>	<p><b><u>Integumentary</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Eczema  <input type="checkbox"/> <input type="checkbox"/> Rosacea  <input type="checkbox"/> <input type="checkbox"/> Psoriasis  <input type="checkbox"/> Other:</p>	<p><b><u>Neurological</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Epilepsy  <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Other:</p>
<p><b><u>Genitourinary</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Urinary Tract Infect.  <input type="checkbox"/> <input type="checkbox"/> Uncontrollable bladder  <input type="checkbox"/> <input type="checkbox"/> Bladder dysfunction  <input type="checkbox"/> Other:</p>	<p><b><u>Blood / Lymph/ Cancer</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Anemia  <input type="checkbox"/> <input type="checkbox"/> Large volume blood loss  <input type="checkbox"/> <input type="checkbox"/> Leukemia  <input type="checkbox"/> <input type="checkbox"/> Cancer                      type: _____                      treatment: _____  <input type="checkbox"/> Other:</p>	<p><b><u>Head / ENT</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Dry mouth  <input type="checkbox"/> <input type="checkbox"/> Headache  <input type="checkbox"/> <input type="checkbox"/> Resp. tract infect.  <input type="checkbox"/> Other:</p>	<p><b><u>Eyes</u></b>  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Glaucoma  <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration  <input type="checkbox"/> <input type="checkbox"/> Cataracts  <input type="checkbox"/> <input type="checkbox"/> Eye Surgery  <input type="checkbox"/> <input type="checkbox"/> Flashes/Floaters</p>	<p>(Eyes continued)  <b>Y N</b>  <input type="checkbox"/> <input type="checkbox"/> Strabismus/Amblyopia  <input type="checkbox"/> <input type="checkbox"/> Dry Eye  <input type="checkbox"/> Other:</p>

**Payment Method:**

Please Check Here If You Are **Self Pay**: \_\_\_\_\_

**Vision Insurance:**

Name of Insurance Plan: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Name of Employer: \_\_\_\_\_ Primary holder SS# \_\_\_\_\_

**Medical Insurance:**

Name of Insurance Plan: \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Group #: \_\_\_\_\_ Name of Primary Insured: \_\_\_\_\_

**Insurance Authorization**

I authorize and request my insurance company to pay directly to the eye doctor benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. ***I agree to be responsible for payment of all services rendered on my behalf or my dependents.***

**Payment Policy:** Payment for your examination is required at the time of service. Optical purchases require a down payment of 50% before your order can be placed and the balance paid in full at the time of dispensing. Unpaid balances older than 45 days are subject to a 10% finance charge. Thank you.

**X** \_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

Dr. Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_

Date: \_\_\_\_\_