Welcome to our office.

Thank you for choosing our practice for your eye care needs. Please take a moment to complete this form.
If you have any questions or concerns, don't hesitate to ask for assistance.

Patient Information

Date _____

Dr. ____
Mr. ____ Last Name _____ First Name _____ Middle Initial _____
Mrs. ___ Home Address _____ Home Phone (____) _____
Ms.____ City _____ State _____ Zip _____ Office Phone (____) _____
Cell Phone (____) _____

Date of Birth_____ Occupation _____
Age _____ Employer_____
Eye Color _____ Driver's License Number and State _____
E-Mail _____

Do you prefer to receive calls at ❑ Home ❑ Work ❑ Cell
Whom may we thank for referring you to us? _____

Insurance Information

Do you plan on using vision insurance for payment? ❑ Yes ❑ No
Name of Insurance _____
Name of plan member _____
Relationship to patient_____
Social Security # of plan member _____ Identification # of patient _____

Vision and Eye Health History

Approximate date of last eye exam _____ Name of Doctor _____
What is your reason for vision care at this time? _____
_____
Have you ever worn contact lenses? Yes / No; Type? ❑ Soft / ❑ Rigid Gas Permeable / ❑ Hard
Are you interested in wearing contact lenses? Yes / No
Do **you** have a history of any of the following?
❑ Glaucoma / ❑ Diabetes / ❑ Cataracts / ❑ Eye Surgery / ❑ Eye Injuries / ❑ Other
Please Explain: _____
Is there a family history of Glaucoma? Yes / No Which Family Member(s)? _____
Is there a family history of Diabetes? Yes / No Which Family Member(s)?_____
Are you taking any medications for your eyes? Yes / No

Medication	Condition
_____	_____
_____	_____

General Health History

Date of last general medical exam _____ Name of Physician _____
Do you use cigarettes/tobacco?_____Alcohol?_____Other substance(s)? _____
List any medications that you're currently taking and the related conditions.

Medication	Condition
_____	_____
_____	_____
_____	_____

List any allergies to medications: _____

Vision Care

To help us better assist you today, please provide us with the following updated information.

Date_____

Name_____ **Address**_____

Home Phone_____
Work_____ **City/State**_____ **Zip Code**_____
Cell _____

Preferred contact number:
- ❑ Home
- ❑ Work
- ❑ Cell

Email Address_____

What is your Occupation?_____

Are you interested in purchasing glasses or prescription sunglasses today?
- ❑ Yes
- ❑ No

Are you experiencing any of the following?
- ❑ Headaches
- ❑ Sensitivity to light
- ❑ Poor near vision
- ❑ Poor distance vision
- ❑ Eye irritation
- ❑ Glare (circle all that apply)
  Computer monitor,
  Night driving,
  Florescent lighting,
  Cell phone,
  Television

Please rate your eye strain/fatigue on a scale of 1-10, 10 being the worst.

_____

To further assist your needs, please circle the appropriate answer:

❑ Are you on a computer more than 4 hours per day?	**Y**	**N**
❑ Do you use your near vision more than 4 hours a day? (Texting, reading, etc.)	**Y**	**N**
❑ Do you participate in any water sports? (Fishing, skiing, etc.)	**Y**	**N**
❑ Do any of your recreational hobbies include flying, golfing, hiking, or biking?	**Y**	**N**

Please list any additional comments or changes in medical history, including new medications:

_____

_____

Visual Field Test:

A new computerized instrument now enables us to check for areas of loss of sight in the central (straight ahead) and peripheral (side view) areas. **It can detect early signs of glaucoma, retinal problems, neurological diseases, macular disorders and headache related illnesses.**

We strongly recommend our patients receive this test in addition to their comprehensive visual analysis. The fee for the test is $45.00.

Would you like to receive this test?
- ❑ Yes
- ❑ No