Thank you for choosing us for your eyecare needs. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Mailing Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian or spouse | Emergency Contact, Relation To Contact | Emergency Phone

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who referred you to our office? _____

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician | City | State | Zip | Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician | City | State | Zip | Phone

PATIENT HISTORY AND INFORMATION

Race

☐ American Indian Or Alaska Native ☐ Native Hawaiian Or Other Pacific Islander
☐ Asian ☐ White
☐ Black Or African American ☐ Declined To Specify
☐ Hispanic Or Latino Other Race _____

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi

Height ft [ ] in [ ] cm/m [ ] ○ ft in ○ cm ○ m **Weight** [ ] ○ lbs ○ kg

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient.The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature | Date

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Current Eye Drops: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Skin	○ Yes ○ No	Pregnant	○ Yes ○ No
		Neurological (Multiple Sclerosis)	○ Yes ○ No	Nursing	○ Yes ○ No

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Smoking Status

Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : _____

Name

Lasik History:

Have you had Lasik/PRK/ICL surgery: ○ Yes ○ No

Would you like more info about Lasik/PRK/ICL: ○ Yes ○ No

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? _____ Distance from Computer? _____

Do you drive? ○ Yes ○ No Mileage to work each way? _____

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	_____	_____	Distance Vision	_____	_____	Near Vision	_____	_____

Which solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____