

PATIENT INFORMATION:

Patient's Name: _____ Age: _____ Male: ___ Female: ___
Address: _____ Marital Status: _____
City / State: _____ ZIP: _____ Home Phone: _____
SS#: _____ - _____ - _____ Birth Date: ____/____/____ Day/Work Phone: _____
E-mail address: _____ Cell Phone: _____
Place of Employment: _____

PERSON RESPONSIBLE FOR BILL / INSURANCE POLICY HOLDER / SPOUSE:

Name: _____ Age: _____ Male: ___ Female: ___
Address: _____ Marital Status: _____
City / State: _____ ZIP: _____ Home Phone: _____
SS#: _____ - _____ - _____ Birth Date: ____/____/____ Day/Work Phone: _____
E-mail address: _____ Cell Phone: _____
Place of Employment: _____

INSURANCE INFORMATION:

Vision insurance: _____ Medical insurance: _____
Name of primary insured: _____ Relationship to patient: _____

GENERAL HEALTH HISTORY FOR PATIENT:

Do you (patient = P) or a family member (F) have any of the following diseases? (Please circle)

Arthritis	P / F	High blood pressure	P / F	STD's	P / F
Asthma/COPD	P / F	Lupus	P / F	Sjogren's Disease	P / F
Heart Disease	P / F	Multiple Sclerosis	P / F	Tuberculosis	P / F
Diabetes	P / F	Seasonal Allergies	P / F	Thyroid Disease	P / F
High Cholesterol	P / F				

Are you under a doctor's care for any reason? Y/N Your doctor is: _____
List all medications to which you are allergic: _____

Do you use recreational drugs, alcohol, cigarettes or cigars? _____

Are you taking any medications? (Please include any eye drops.) If yes, please list them:

OCULAR HEALTH HISTORY FOR PATIENT:

Do you (patient = P) or a family member (F) have any of the following diseases? (Please circle)

Cataracts	P / F	Glaucoma	P / F	Macular Degeneration	P / F
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Do you experience any of the following ocular problems? (Please circle appropriate answers)

Blurred vision	Double vision	Floaters	Light sensitive	Tearing
Burn-ache-strained	Eye pain	Glare	Redness	Visual distortions
Dry eyes	Flashes	Itching	Styes	

Have you ever had an eye injury? If yes, describe: _____
Have you ever had eye surgery? If yes, describe: _____

Date of last eye exam: _____ Do you wear glasses? Y/N Contact lenses? Y/N

What is the main reason for scheduling your appointment? _____
