

# WELCOME TO OUR OFFICE



## Patient Information

Today's Date \_\_\_\_\_

Last \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

How do you prefer to be contacted?

(Indicate #1 and #2 Choice):

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Text \_\_\_\_\_ Email \_\_\_\_\_

Patient's SSN \_\_\_\_\_

Employer (or School) \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parent's Work) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Sex M F Primary Language \_\_\_\_\_

Decline Race(s) \_\_\_\_\_

Decline Ethnicity \_\_\_\_\_

**What is the major purpose of this visit?**

\_\_\_\_\_

Any problems with your current contact lenses or

glasses? \_\_\_\_\_

\_\_\_\_\_

**VERY IMPORTANT! NEW PATIENTS ONLY:**

Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

Another Dr.

Insurance List

Saw Sign/Building

Newspaper

Mailer

Web Page

Other

## Insurance Information

*Please note that insurance usually does NOT cover the Contact Lens Evaluation.*

Vision Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Do you participate in a flex spending account?

Yes

No

## Lifestyle Questions

**Do you.....(check box if your answer is yes)**

..work at a computer? \_\_\_\_\_Hours/week

..think you might benefit from thinner, lighter lenses?

..have interest in a "test drive" of the latest contact lens designs

..spend time outdoors? How much? \_\_\_\_\_Hours/week

..ski or snowboard?

..do detailed fine work?

..play music? Sing?

..have prescription sunwear?

..prefer not to wear your glasses at times?

..want information on Laser Vision Correction surgery?

..have children?

..have family members in need of eyecare?

**Other Hobbies:** \_\_\_\_\_

**Have you ever experienced, been diagnosed or treated for any of the following?**

Cataracts

Redness

Macular Degeneration

Burning

Glaucoma

Itching

Diabetic Retinopathy

Tearing

Dry Eye

Discharge

Eye Infection

Blurred Vision

Eye Allergy

Eyestrain

Floaters/Flashes of Light

Eye Pain

Iritis or Uveitis

Sunlight Sensitivity

Retina defects

Headache

Crossed Eye/Eye Turn

Poor Night Vision

Lazy Eye

Double Vision

Eye Injury

Total Loss of Vision

Other eye disorders \_\_\_\_\_

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 _____		
Town _____		
Date of Last Physical Check-up _____		
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins, & birth control pills) _____		
_____		
_____		
Allergies to medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, what medications? _____		
_____		
Other Allergies? _____		
_____		
Have you had any surgeries?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, list surgeries? _____		
_____		
Do you use cigarettes/tobacco, alcohol, or other substances?		
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nursing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Height _____	Weight _____	
<b>Have you ever been diagnosed or treated for the following health problems?</b>		
	<b>Yes</b>	<b>No</b>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes, Type _____	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you prefer clear contact lenses or colored contact lenses?	
	<input type="checkbox"/> Clear <input type="checkbox"/> Colored
If you wear bifocals, do the lines or head tilting bother you?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship (Mother's or Father's side)
Cancer	<input type="checkbox"/> _____
Diabetes, Type _____	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____
Thyroid Disorder	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/> _____
Cataract	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Blindness	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Other	<input type="checkbox"/> _____