

Dr. Initials \_\_\_\_\_

**PATIENT HISTORY**

Acct. # \_\_\_\_\_

Today's date \_\_\_\_\_

If you are **NOT** a new patient and **NONE** of your information has changed since your last visit, please sign your name on the following line and return to the receptionist \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Preferred name \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

SS# \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency contact person: Name \_\_\_\_\_ Phone Number(s) \_\_\_\_\_

Whom may we thank for your referral? Name \_\_\_\_\_ Address \_\_\_\_\_

**PERSONAL EYE INFORMATION** (please circle Y or N where indicated)

What are your vision concerns? \_\_\_\_\_ Have you had any injuries to your eye(s) or surgeries? If yes, please explain in detail giving dates \_\_\_\_\_

What was the date of your most recent eye examination and by whom? \_\_\_\_\_

Do you work on a computer? Y/N If yes, hours each day? \_\_\_\_\_ Do you have trouble with glare? Y / N

Dry Eyes? Y / N Blurred Vision? Y / N. In what hobbies do you participate? \_\_\_\_\_

Do you wear glasses? Y / N Contacts? Y / N If yes, what type contacts to you wear? \_\_\_\_\_

If you have never worn contacts, would you consider wearing them? Y / N

Have you contemplated laser vision correction? Y / N

Do you object to having your eyes dilated? Y / N (Dilating the eyes allows for a more inclusive examination for glaucoma, diabetes, hypertension, and ocular tumors).

**MEDICAL HISTORY** (please circle Y or N where indicated)

What is your general health? \_\_\_\_\_ Do you or your immediate family have any of the following?

Glaucoma Y / N relation \_\_\_\_\_ Cataracts Y / N relation \_\_\_\_\_ High blood pressure Y / N

relation \_\_\_\_\_ Macular Degeneration Y / N relation \_\_\_\_\_ Retinal Detachment Y / N relation \_\_\_\_\_

Diabetes Y / N relation \_\_\_\_\_ If yourself, type of diabetes and date of diagnosis \_\_\_\_\_

Do you have a problem with any of the following ?

Blood Lymph Y / N Gastrointestinal Y / N Mental Y / N

Cardiovascular Y / N Genitourinary Y / N Musculoskeletal Y / N

Ear/Nose/Throat Y / N Headaches Y / N Nervous Y / N

Endocrine (glands) Y / N Immunologic Y / N Respiratory Y / N

Eyes Y / N Integumentary (skin) Y / N

Do you have allergies? Y / N If yes, please list \_\_\_\_\_

Please list any current medication(s) \_\_\_\_\_

Do you use tobacco in any form? Y / N Alcohol? Y / N Other substances? Y / N

Date of last tetanus shot \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Family doctor \_\_\_\_\_ Phone \_\_\_\_\_

Do you have an advance directive for health care (living will)? \_\_\_\_\_

**STATEMENT OF FINANCIAL POLICY**

Payment is expected when services are fulfilled. If corrective lenses or glasses are ordered, you may either pay the balance in full or pay a deposit of half the balance before the order is placed. The balance of the account is required before the glasses or lenses are dispensed.

What will be your method of payment? Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_ Insurance \_\_\_\_\_