TODAY'S DATE___/___/___

PATIENT INFORMATION

LAST NAME _____ ***FIRST NAME*** _____ ***M*** ___ ***F*** ___ ***BIRTH DATE*** ___/___/___

ADDRESS _____ ***CITY*** _____ ***STATE*** _____ ***ZIP*** _____

HM PHONE(_____)_____ ***WK PHONE***(_____)_____ ***CELL PHONE***(_____)_____

EMPLOYER _____ ***ADDRESS*** _____ ***OCCUPATION*** _____

GUARDIAN/GUARANTOR'S NAME _____ ***HM PHONE***(_____)_____
(*If under 18 or different from pt. name*)

E-MAIL ADRESS _____ ***REFERERRED BY*** _____

INSURANCE INFORMATION

PLAN NAME _____ ***GROUP*** _____

INSURED NAME _____ ***RELATIONSHIP TO PT.*** _____ ***SELF*** _____ ***SPOUSE*** _____ ***CHILD***

INSURED ID/GROUP # _____ ***INSURED DOB*** ___/___/___ ***INSURED SS #*** _____-_____-_____

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAYS EXAM? _____

_____

_____

DATE OF LAST EYE EXAM___/___/___ **FROM DR.**_____ **OR PREVIOUS PT.**_____ **AGE OF PRESENT GLASSES**_____ **CONTACTS**_____

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENT, PARENTS, BROTHER OR SISTER) **HAVE ANY OF THESE CONDITIONS?**

	SELF	RELATIVE	NONE
DIABETES	○	○	○
HIGH BLOOD PRESSURE	○	○	○
THYROID PROBLEMS	○	○	○
HEART DISEASE	○	○	○
CANCER	○	○	○
ASTHMA	○	○	○

	SELF	RELATIVE	NONE
GLAUCOMA	○	○	○
CATARACTS	○	○	○
RETINAL DISEASE	○	○	○
EYE SURGERY	○	○	○
EYE INJURY	○	○	○
OTHER_____	○	○	○

	YES	NO
DO YOU SEE DOUBLE?	○	○
FREQUENT HEADACHES?	○	○
ARE YOU PREGNANT?	○	○
EYES BEEN DIALATED?	○	○

(IF YES TO DIALATED WHAT YEAR)_____

PRIMARY CARE DR._____

PLEASE EXPLAIN ANY POSITIVE FINDINGS: _____

_____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)**? PLEASE LIST.** _____

_____

ARE YOU TAKING ANY MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)**? PLEASE LIST.** _____

_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR OTHER? IF YES, PLEASE EXPLAIN. _____

(IF MORE SPACE IS NEEDED TO ANSWER ANY QUESTION PLEASE USE REVERSE SIDE) THANK YOU!

PT. SIGNATURE _____ *(GUARDIAN IF UNDER 18 OR GUARANTOR'S OF PT.)*