



PATIENT INFORMATION
(PLEASE PRINT)

Date: _____

Patient's Name _____ Male Female
(Last) (First) (Middle Initial)

Birth Date _____ Age _____ Social Security Number _____

Mailing Address _____

(City) (State) (Zip Code)

Home Phone _____ Cell Phone _____

Email Address _____

Employer/School _____ Phone _____

Spouse Name & Place of Employment _____
(Parent if Minor)

Status: Minor Single Married Separated Divorced Widowed

Physician _____ Last Exam _____ Phone _____

Former Optometrist _____ Phone _____

Major Medical Insurance Co. _____

Vision Care Insurance Co. _____

Whom may we thank for referring you to this office? _____

Emergency Contact Info:

Name _____ Relationship _____

Home Phone _____ Work/Cell Phone _____

I will be paying today by: Cash Check Credit Card

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature [Parent (if minor) or Legal Guardian]

Date

Print Name

Relationship (if minor)

MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION REGARDING YOUR MEDICAL HISTORY

To help us care for you, please explain the reason for your visit with us today.

OCULAR HISTORY

Please circle the response to each of the following questions:

Do you wear glasses? YES NO

Do you wear contacts? YES NO

Have you ever been diagnosed as having: CATARACTS GLAUCOMA RETINAL CONDITION
DRY EYES LAZY EYE DOUBLE VISION OTHER:_____ If none, check here

Have you ever had: Eye surgery? YES NO If yes, explain_____
Eye injury? YES NO If yes, explain_____

Date of your last exam:_____ by Dr._____

MEDICAL HISTORY

Please circle the response to each of the following questions:

HIGH BLOOD PRESSURE HEART DISEASE CIRCULATION/STROKE DIABETES
ARTHRITIS THYROID DISEASE BREATHING CONDITION CANCER
OTHER:_____

FAMILY HISTORY

Please circle if any member of your family ever had: If none, please check here

CATARACTS GLAUCOMA RETINAL CONDITION DIABETES

MEDICATIONS

Please list all current medications and dosage (if known): If none, please check here

_____	_____
_____	_____
_____	_____
_____	_____

Please list all current eye drops and dosage (if known): If none, please check here

_____	_____
_____	_____
_____	_____

Please list all allergies: If none, please check here

Do you use tobacco products (i.e., cigarettes, cigars, chew tobacco)? Yes No

Do you drink? Social Occasional Daily Never

Please list any hobbies:_____