WELCOME TO OUR OFFICE! *Please help us provide you with the best possible care by providing your information below:*

Name: _____ Date of Birth: _____
Nickname: _____ Social Security Number: _____

Street Address: _____ Employer Name: _____
City/State/Zip: _____ Employer Phone: _____
Occupation: _____

Home Phone: _____
Cell Phone: _____ Spouse's Name: _____
Email Address: _____ Parent/Guardian Name (if child): _____

Primary Care Doctor: _____ How did you select our office for your eye care? (check one):
Last Medical/Physical Exam: _____ ☐ Friend/Relative- Name: _____
Last Eye Exam: _____ ☐ Internet- Website: _____
☐ Phonebook ☐ Insurance

What brings you in to see us today?: _____

REVIEW OF SYSTEMS: *(Please check appropriate boxes if **you** currently, or have ever, had any UNUSUAL or MAJOR problems in the following areas)*

	PRESENT	PAST	
OCULAR/ EYES	☐	☐	Eye Surgery (please specify): _____
	☐	☐	Eye Injury (please specify): _____
	☐	☐	Cataract
	☐	☐	Macular Degeneration
	☐	☐	Glaucoma
	☐	☐	Retinal Detachment
	☐	☐	"Lazy Eye"/Amblyopia
	☐	☐	Eye Turn/Crossed Eyes/Strabismus
	☐	☐	Stye/Chalazion
	☐	☐	Dry Eye
	☐	☐	Excessive Tearing/Watering
	☐	☐	Flashes/Floaters in Vision
	☐	☐	Glare/Light Sensitivity
ALLERGIES/ EAR, NOSE, THROAT	☐	☐	Seasonal Allergies/Hayfever
	☐	☐	Sinus Congestion
	☐	☐	Post-Nasal Drip/Runny Nose
	☐	☐	Chronic Cough
	☐	☐	Dry Throat/Mouth
CARDIOVASCULAR/ HEART	☐	☐	High Blood Pressure
	☐	☐	Vascular Disease
	☐	☐	Heart Attack
	☐	☐	High Cholesterol
CONSTITUTIONAL	☐	☐	Fever
	☐	☐	Weight loss/Weight gain
ENDOCRINE	☐	☐	Diabetes
	☐	☐	Thyroid- High/Low
GASTROINTESTINAL	☐	☐	Diarrhea
	☐	☐	Constipation
GENITOURINARY	☐	☐	Bladder/Kidney disorder (please specify): _____
HEMATOLOGIC	☐	☐	Anemia
	☐	☐	Bleeding Problems
IMMUNOLOGIC	☐	☐	HIV/AIDS
	☐	☐	Tuberculosis (TB)
INTEGUMENTARY	☐	☐	Skin disorder (please specify): _____
MUSCULOSKELETAL	☐	☐	Rheumatoid Arthritis
	☐	☐	Muscle/Joint Pain
NEUROLOGICAL	☐	☐	Headaches
	☐	☐	Migraines
	☐	☐	Seizures
RESPIRATORY	☐	☐	Asthma
	☐	☐	COPD
	☐	☐	Emphysema

PLEASE CONTINUE ON BACK →

PERSONAL MEDICAL HISTORY: *(Please check appropriate boxes if **you** currently, or have ever, had any complications in the following areas **except for eyes**)*

☐ Hospitalizations (please list): _____

☐ Surgeries (please list): _____

☐ Injuries (please list): _____

Please list ALL medications currently taken (including oral contraceptives, aspirin, over-the-counter, and home remedies):

_____

Do you have any drug allergies? (please list): _____

☐ Yes _____

☐ No _____

FAMILY HISTORY: *(Please check the box of appropriate family members that have the following conditions. NOTE: This section is **not** about you or your spouse)*

Disease/Condition	Relationship to You									
	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Aunt	Uncle
Amblyopia /"Lazy Eye"	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus/Crossed Eyes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Detachment/Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

YOUR GLASSES & CONTACT LENSES:

Do you currently wear glasses?: ☐ Yes ☐ No How old are your glasses lenses?: _____

Do you currently wear contact lenses?: ☐ Yes ☐ No If yes, how old is your present pair?: _____

If no, are you interested in contacts?: _____

Are your contacts: ☐ Hard/RGP ☐ Soft ☐ Toric (astigmatism) ☐ Monovision ☐ Bifocal

Brand name of contacts: _____ Do you sleep in your contacts? ☐ Yes ☐ No

Have you worn contact lenses in the past?: ☐ Yes ☐ No

EXAMINATION FEES & CONTACT LENS POLICY: *(Please sign below, indicating your understanding)*

All fees are due at time of service. If insurance is to be used as payment, I request that payment of Authorized Medicaid/Medicare/ Insurance and affiliate benefits be made to the physician furnishing services on my behalf. I authorize the physician and staff to furnish information to Medicaid/Medicare/Insurance concerning my medical condition, illness, and treatment in order to determine benefits related to services rendered. I understand that any unpaid balance not covered by this policy will be payable by me, the patient/parent or guardian. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of any professional services/procedures rendered. I agree to take full responsibility for any unpaid balances, and that such payment will be made in full to this physician's office for services.

Contact lens fitting and evaluation fees are time-limited. They are intended to include all contact lens related visits for up to 6 weeks from the initial visit. Beyond this, additional fees for services may be charged.

Patient Signature: _____ Date: _____

(or parent/guardian, if applicable)