PATIENT INFORMATION

GENERAL

_____/_____/_____
DATE

(LAST) _____ (FIRST) _____ (MI) _____ _____
NAME *NICK NAME*

_____ (CITY) _____ (STATE) _____ (ZIP CODE) _____
ADDRESS

(_____)_____ (_____)_____ _____
PRIMARY PHONE - HOME / WORK / CELL *SECONDARY PHONE - HOME / WORK / CELL* *EMAIL ADDRESS*

_____-_____-_____ ____/____/_____ ☐ M ☐ F ☐ MAR ☐ DIV ☐ WID ☐ SING
SOCIAL SECURITY NUMBER *BIRTH DATE* *GENDER* *MARITAL STATUS*

_____ _____ _____ ☐ DECLINE
EMPLOYER/SCHOOL *OCCUPATION* *LANGUAGE/RACE/ETHNICITY*

_____/ (_____)_____
EMERGENCY CONTACT/RELATION *EMERGENCY CONTACT PHONE*

☐ Mail ☐ Online Ad ☐ Web Search ☐ Friend/Family Member ☐ Insurance Plan ☐ Other: _____
HOW DID YOU HEAR ABOUT US?

MEDICAL HISTORY

ARE YOU PREGNANT OR NURSING? Y / N DO YOU SMOKE? Y / N HAVE YOU EVER SMOKED? Y / N

LIST ALL **MEDICAL** CONDITIONS (I.E. HIGH BLOOD PRESSURE, DIABETES, HIGH CHOLESTEROL, DEPRESSION, ETC.): _____

_____

LIST ALL **EYE** CONDTIONS (I.E. GLAUCOMA, CATARACTS, MACULAR DEGENERATION, LAZY EYE, ETC.): _____

_____

LIST ALL **MEDICATIONS** (INCLUDE PRESCRIPTION MEDS, OTC MEDS, AND ANY EYE DROPS USED): _____

_____

LIST ALL ***MEDICATION ALLERGIES*** **AND ANY** ***OTHER ALLERGIES*** (I.E. LATEX, ENVIRONMENTAL, ETC.): _____

_____

LIST ALL **SURGERIES** (MEDICAL OR EYE): _____

_____

NAME OF PRIMARY CARE PHYSICIAN: _____ PHONE: (_____)_____

EYE HISTORY

DATE OF LAST EYE EXAM: _____ CURRENTLY WEAR GLASSES? Y / N AGE OF GLASSES: _____

CURRENTLY WEAR CONTACT LENSES? Y / N HAVE YOU EVER WORN CONTACT LENSES? Y / N

HAPPY WITH YOUR CURRENT CONTACT LENSES? Y / N INTERESTED IN WEARING CONTACT LENSES? Y / N

DATE OF LAST TIME EYES WERE DILATED? _____ WEAR SUNGLASSES OR TRANSITIONS? Y / N

PATIENT INFORMATION

CHECK ANY OF THE FOLLOWING SYMPTONS YOU ARE CURRENTLY EXPERIENCING, OR HAVE EXPERIENCED RECENTLY:

- ☐ BLURRY DISTANCE VISION
- ☐ BLURRY NEAR VISION
- ☐ DOUBLE VISION
- ☐ LOSS OF VISION
- ☐ DRYNESS
- ☐ BURNING
- ☐ ITCHING
- ☐ REDNESS
- ☐ DISCHARGE
- ☐ FREQUENT HEADACHES
- ☐ SANDY OR GRITTY FEELING
- ☐ EXCESS TEARING
- ☐ EYE INFECTION
- ☐ EYE PAIN OR SORENESS
- ☐ FLASHES OF LIGHT
- ☐ FLOATING SPOTS
- ☐ LIGHT SENSITIVITY
- ☐ NIGHT GLARE / SUN GLARE / COMPUTER GLARE
- ☐ EYE FATIGUE WITH READING / COMPUTER

FAMILY HISTORY

CHECK ANY OF THE FOLLOWING CONDITIONS YOUR **BLOOD RELATIVES (I.E. MATERNAL/PATERNAL GRANDMOTHER OR GRANDFATHER, MOTHER, FATHER, BROTHER, SISTER) HAVE EVER HAD. LIST RELATIVE(S) IN BLANK PROVIDED:*

	RELATIVE:		*RELATIVE:*
☐ DIABETES – TYPE 1 / TYPE 2	_____	☐ CATARACTS	_____
☐ HIGH BLOOD PRESSURE	_____	☐ GLAUCOMA	_____
☐ THYROID DISEASE	_____	☐ MACULAR DEGENERATION	_____
☐ HEART DISEASE	_____	☐ DIABETIC EYE DISEASE	_____
☐ LUPUS	_____	☐ RETINAL DETACHMENT	_____
☐ ARTHRITIS	_____	☐ EYETURN/AMBLYOPIA	_____
☐ MULTIPLE SCLEROSIS	_____	☐ OTHER CONDITIONS NOT LISTED	_____
☐ CANCER (PLEASE LIST TYPE)	_____		_____
_____		☐ FAMILY HISTORY UNKNOWN	

INSURANCE INFORMATION

VISION INSURANCE: _____ GROUP NAME OR #: _____
PRIMARY INSURED NAME: _____ RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT
PRIMARY INSURED BIRTH DATE: _____ / _____ / _____ INSURED ID # OR MEMBER #: _____

PRIMARY MEDICAL: _____ GROUP NAME OR #: _____
PRIMARY INSURED NAME: _____ RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT
PRIMARY INSURED BIRTH DATE: _____ / _____ / _____ INSURED ID # OR MEMBER #: _____

SECONDARY MEDICAL: _____ GROUP NAME OR #: _____
PRIMARY INSURED NAME: _____ RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐PARENT
PRIMARY INSURED BIRTH DATE: _____ / _____ / _____ INSURED ID # OR MEMBER #: _____

PLEASE READ: CONSENT TO EYE DILATION

Dilation of your eyes involves uses drops to relax the muscle that controls the pupil size, allowing the pupil to fully open. It takes 20 minutes for the drops to take effect before the doctor can complete the dilation. Side effects of dilation can include short-term blurred vision up close, and in some cases far away, as well as sensitivity to light. Patients with high prescriptions, new floaters and flashes, diabetes, and high blood pressure are STRONGLY advised to have their eyes dilated yearly. In addition, patients with a family history of glaucoma, macular degeneration or blindness should follow the same guidelines. REFUSAL TO HAVE YOUR PUPILS DILATED MAY CAUSE YOUR DOCTOR TO BE UNABLE TO DETECT CERTAIN DISEASES. **Consent** - I understand the importance of dilation, and decide to (please check one of the following):

- ☐ AGREE to have my eyes dilated (or, if patient is a minor, give permission to have my child's eyes dilated) today
- ☐ REFUSE to have my eyes dilated today