

**PATIENT INFORMATION**

Date: \_\_\_\_\_ Insurance: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

(If 18 years or younger) Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ SSN: \_\_\_\_\_ Marital Status:  S  M Gender:  M  F

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Last Medical Exam: \_\_\_\_\_

Other Physician (Specialist): \_\_\_\_\_ Last Eye Exam: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

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**PATIENT OCULAR HISTORY**

Do you wear glasses?  Yes  No If yes, how old is your current pair of lenses? \_\_\_\_\_

Do you plan to purchase a pair of glasses today?  Yes  No

Are you bothered by:

Glare  Yes  No Oncoming Headlights  Yes  No

Computer Use  Yes  No How many hours a day are you at the computer? \_\_\_\_\_

Other \_\_\_\_\_

Do you wear contact lenses?  Yes  No  RGP  Soft  Soft Disposable

How many hours a day do you wear them? \_\_\_\_\_ Are they comfortable?  Yes  No

Are there ever times you wish you didn't have to wear glasses? \_\_\_\_\_

Would you like to discuss the option of laser surgery? \_\_\_\_\_

Hobbies: \_\_\_\_\_

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**Ocular Complaints** (please check all that apply)

Allergy  Field Loss  Foreign Body  Lumps  Red Eye

Burn  Floaters  Headache  Migraine  Trauma

Eye Turn  Flashers  Lesions  Pain  Other \_\_\_\_\_

**Medical Conditions / Ocular Surgeries:** \_\_\_\_\_

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Please list any medications you are currently taking: \_\_\_\_\_

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Please list any drug allergies: \_\_\_\_\_

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**OCULAR / MEDICAL FAMILY HISTORY** (Please write the relationship on the line or write "Self")

Blindness \_\_\_\_\_  Crossed Eyes \_\_\_\_\_  Glaucoma \_\_\_\_\_  Macular Degeneration \_\_\_\_\_

Diabetes \_\_\_\_\_  Cancer/Type \_\_\_\_\_  Kidney Disease \_\_\_\_\_  High/Low Blood Pressure \_\_\_\_\_

Cataract \_\_\_\_\_  Cataract Surgery \_\_\_\_\_  Arthritis \_\_\_\_\_  Retinal Detachment \_\_\_\_\_

Heart Disease \_\_\_\_\_  Thyroid Disease \_\_\_\_\_

**SOCIAL HISTORY**

I would prefer to discuss this directly with my doctor.

Do you use tobacco products?       Yes    No      If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?               Yes    No      If yes, type/amount/how long: \_\_\_\_\_

Do you use narcotics?               Yes    No      If yes, type/amount/how long: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently, or have you ever had any problems in the following areas:

**Constitutional**

Fever                                       Yes    No

Weight Loss/Gain                       Yes    No

**Neurological**

Headaches                               Yes    No

Migraines                                 Yes    No

Seizures                                  Yes    No

**Endocrine**

Thyroid/Other Glands                 Yes    No

**Ears, Nose, Mouth, Throat**

Allergies/Hay Fever                  Yes    No

Sinus Congestion                      Yes    No

Runny Nose                              Yes    No

Post-Nasal Drip                        Yes    No

Chronic Cough                          Yes    No

Dry Throat/Mouth                     Yes    No

**Respiratory**

Asthma                                    Yes    No

Chronic Bronchitis                    Yes    No

Emphysema                              Yes    No

**Psychiatric**

Yes    No

**Vascular/Cardiovascular**

Diabetes                                  Yes    No

Heart Pain                                Yes    No

High Blood Pressure                  Yes    No

Vascular Disease                       Yes    No

**Gastrointestinal**

Diarrhea                                  Yes    No

Constipation                           Yes    No

**Genitourinary**

Genital Issues                          Yes    No

Kidney Issues                          Yes    No

Bladder Issues                          Yes    No

**Bones/Joints/Muscles**

Rheumatoid Arthritis                 Yes    No

Muscle Pain                              Yes    No

Joint Pain                                 Yes    No

**Lymphatic/Hematologic**

Anemia                                    Yes    No

Bleeding Problems                    Yes    No

**Allergic/Immunologic**

Yes    No

If you answered yes to any of the above or have a condition not listed, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date