

Mr. \_\_\_ Mrs. \_\_\_ Ms. \_\_\_ Dr. \_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_

Patient  New /  Previous

Address \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

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

Last Eye Exam mo \_\_\_/yr \_\_\_

Referred by:  Family  Co-worker  Insurance manual  Google  Our website  
 Friend  Drove by (sign)  Insurance website  Other Search Engine  Other \_\_\_\_\_

**INSURANCE**

Vision \_\_\_\_\_ ID# \_\_\_\_\_ Member's Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_

Medical \_\_\_\_\_ ID# \_\_\_\_\_ Member's Name \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_

**Medical History** Last Medical Exam \_\_\_/\_\_\_/\_\_\_ Medical Dr's Name \_\_\_\_\_

Do you have any allergies to medications?  no  yes If yes, explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had:  
\_\_\_\_\_  
\_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

Are you pregnant and/or nursing?  no  yes  
Do you wear glasses?  no  yes If yes, how old is your present pair of glasses? \_\_\_\_\_  
Do you wear contact lenses?  no  yes If yes, what is the brand and power? \_\_\_\_\_  
Are they comfortable?  no  yes How often do you replace them? \_\_\_\_\_

If you are a previous patient and there are no changes in your eye symptoms or family history you may check the appropriate box and skip the rest of this page.  No change in eye symptoms  No change in Family History

**Eye Symptoms**

**Family History** Please indicate any family history (parents, grandparents, siblings, children, living or deceased)

Relationship \_\_\_\_\_

Loss of Vision  no  yes  
Blurred Vision  no  yes  
Distorted Vision/Halos  no  yes  
Loss of Side Vision  no  yes  
Double Vision  no  yes  
Dryness  no  yes  
Mucous Discharge  no  yes  
Redness  no  yes  
Sandy or Gritty Feeling  no  yes  
Itching  no  yes  
Burning  no  yes  
Foreign Body Sensation  no  yes  
Excess Tearing/Watering  no  yes  
Glare/Light Sensitivity  no  yes  
Eye Pain or Soreness  no  yes  
Chronic Infection of Eye/Lid  no  yes  
Sties or Chalazion  no  yes  
Flashes/Floaters in Vision  no  yes  
Tired Eyes  no  yes

Blindness  no  yes  
Cataract  no  yes  
Crossed Eyes  no  yes  
Glaucoma  no  yes  
Macular Degeneration  no  yes  
Retinal Detachment  no  yes  
Retinal Disease  no  yes  
Arthritis  no  yes  
Cancer  no  yes  
Diabetes  no  yes  
Heart Disease  no  yes  
High Blood Pressure  no  yes  
Kidney Disease  no  yes  
Lupus  no  yes  
Thyroid Disease  no  yes  
Other \_\_\_\_\_  no  yes

**Patient Signature** \_\_\_\_\_