

# Welcome To Our Office

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Home/Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_

Primary Vision Insurance: \_\_\_\_\_ Secondary Vision Insurance: \_\_\_\_\_

Primary Medical Insurance: \_\_\_\_\_ Secondary Medical Insurance: \_\_\_\_\_

How did you hear about our office?

- I'm a returning Patient
- Doctor Referral (Write name in box below)
- Friend (Write name in box below)
- Yellow Pages
- Saw Sign / Building
- Insurance listing
- Web page
- Other: \_\_\_\_\_

Name of person who referred you: \_\_\_\_\_

## **MEDICAL HISTORY HAVE YOU HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?**

Gastrointestinal	Yes	No	Not Sure
Ears/Nose/Throat	Yes	No	Not Sure
Cardiovascular	Yes	No	Not Sure
Respiratory	Yes	No	Not Sure
High Blood Pressure	Yes	No	Not Sure
Neurological	Yes	No	Not Sure
Urinary	Yes	No	Not Sure
Muscles/Bones	Yes	No	Not Sure
Skin	Yes	No	Not Sure
Eyes	Yes	No	Not Sure
Endocrine	Yes	No	Not Sure
Blood/Lymph	Yes	No	Not Sure
Allergic/Immunological	Yes	No	Not Sure
Headaches	Yes	No	Not Sure
Mental	Yes	No	Not Sure

**List your medications followed by what they are for (ex. Insulin/Diabetes).**

Medication / Purpose

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Are you diabetic? Yes No      If yes, year of diagnosis \_\_\_\_\_

Are you allergic to any medication? Yes No Medications I am allergic too: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

List any surgeries: \_\_\_\_\_

**FAMILY HISTORY - DOES ANY OF YOUR IMMEDIATE FAMILY HAVE ANY OF THESE CONDITIONS?**

High Blood Pressure	Yes	No	Who? _____
Diabetes	Yes	No	Who? _____
Glaucoma	Yes	No	Who? _____
Macular Degeneration	Yes	No	Who? _____
Retinal Detachment	Yes	No	Who? _____
Cataracts	Yes	No	Who? _____

**PERSONAL EYE INFORMATION**

Have you had any eye surgeries, injuries or serious conditions? Yes No If yes, please describe: \_\_\_\_\_

Have you had any of these symptoms in the last week (check all that apply)?

- |   |  |
|---|--|
| <input type="checkbox"/> Redness                                  | <input type="checkbox"/> Sensitivity to smoke                                      |
| <input type="checkbox"/> Dryness                                  | <input type="checkbox"/> Sensitivity to wind                                       |
| <input type="checkbox"/> Sandy or gritty sensation                | <input type="checkbox"/> Sensitivity to computer glare                             |
| <input type="checkbox"/> Itching                                  | <input type="checkbox"/> Sensitivity to air conditioning or heaters                |
| <input type="checkbox"/> Excess watering or tearing               | <input type="checkbox"/> Sensitivity to light                                      |
| <input type="checkbox"/> Excess mucous discharge                  | <input type="checkbox"/> Sensitivity to contact lenses (dryness, irritation, etc.) |
| <input type="checkbox"/> Blurred vision that clears upon blinking |  |

If you checked anything above, are your symptoms worse:

- In the morning
- Later in the day/evening
- Same all day long

Do you ever wear (check all that apply)?

- Prescription Glasses
- Computer Glasses
- Prescription Sunglasses
- Non Prescription Sunglasses
- Soft Contact Lenses
- Hard (Gas-permeable) contact lenses
- Non Prescription Reading Glasses

Tell us why you are here today (check all that apply):

- New Glasses
- New Glasses (if there is a change in prescription)
- New Contacts
- New Contacts (possibly but need more information first)
- Eye Health problem
- Eye Comfort problem
- Academic problem
- Other: \_\_\_\_\_

Do you use a computer? Yes No      Number of hours per day? \_\_\_\_\_

Are there any times when you wish your vision was better? Yes No

If yes, please describe below:

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**Is there anything we forgot to ask?**

Please tell us anything you would like us to know about your visit so that we can better serve you:

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