Account #: ________________ Name: ______________________________________ Date: __________________________

LAST NAME FIRST NAME MI

Welcome to our office! Please complete front AND back of forms and return them to the receptionist.
(PLEASE PRINT)

Briefly explain the reason for your visit: ____

____

Family Physician: ______________________________________ did he/she refer you to us? ☐ Yes ☐ No

Family Physician Phone # and Address: ____

How did you hear about our office? (*Circle One)*

Friend/Relative/Other Patient: ____

Dr. _____________________________________ Other: ____

PHARMACY INFORMATION

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

To better help your doctor diagnose and treat your particular visual difficulties, please check all those that apply:

I wear or have worn:

☐ No vision correction ☐ Glasses to see at a distance ☐ Glasses for near work ☐ Contacts

It is difficult to *(even while wearing my contacts or glasses):*

☐ read newspapers/books ☐ watch television ☐ see steps and/or curbs ☐ drive during the day

☐ do computer work ☐ sew ☐ read traffic signs ☐ drive during the night ☐ enjoy recreational activities

☐ other(s):

I currently have problems with:

☐ glare ☐ halos around lights ☐ blurred vision ☐ hazy vision

☐ headaches ☐ seeing in dim light ☐ poor night vision ☐ tired eyes

I enjoy the following activities/hobbies *(i.e. golfing, swimming, reading, etc.):*

1. ____________________________ 2. ____________________________ 3. ____________________________

Date of your last eye examination: ______ / ______ / _______

Who performed the examination: ____

If you wear glasses, how old are they?: ____

Dear Patients- It is your responsibility to please make us aware of all insurance information that you have, including any possible vision insurance. We need this information at the time of your visit to process your claim correctly. Additionally, please verify your eligibility of your benefits & coverage before your appointment. Thank you for your assistance. We look forward to providing you with the best eye care possible.

Name: DOB / / Date:

List any **medications** you currently take (Rx and over-the-counter): ____

____

Do you have **allergies** to any medications? ☐ **YES** ☐ **NO**

If YES, list the medications: ____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

____

List any **surgeries** you have had (cataract, appendectomy): ____

____

Do you *currently* have any problems in the following areas? If YES, please provide additional information:

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesteroemia, anemia problems related to blood transfusion, etc.)			

ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY **(Mother, Father, Grandparent, Sibling)**

Has any member of your family had these diseases (circle all that apply)? ☐ YES ☐ NO ☐ UNKNOWN

Blindness, Cataract, Glaucoma, Macular Degeneration, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease: ______________________________

SOCIAL HISTORY

Have you ever had a blood transfusion?..................... YES NO

Do you drink alcohol?................ ☐ YES ☐ NO If YES, how much? ______________________________

Do you smoke? .... ☐ YES ☐ NO If YES, how much? ______________How many years? ______________

Do you use recreational drugs?.. ☐ YES ☐ NO If YES, how much? ______________How many years? ______________

Physician's Signature: ______________________________ Date: ______________________________

UPDATE FORM FOR: PMx, PSHx, Medications, Allergies, Review of Systems, Social Hx

1. Date reviewed and updated: ______________ Changes: ☐ YES ☐ NO Tech: ______________________________
   Changes: ______________________________

2. Date reviewed and updated: ______________ Changes: ☐ YES ☐ NO Tech: ______________________________
   Changes: ______________________________

3. Date reviewed and updated: ______________ Changes: ☐ YES ☐ NO Tech: ______________________________
   Changes: ______________________________

4. Date reviewed and updated: ______________ Changes: ☐ YES ☐ NO Tech: ______________________________
   Changes: ______________________________

5. Date reviewed and updated: ______________ Changes: ☐ YES ☐ NO Tech: ______________________________
   Changes: ______________________________

6. Date reviewed and updated: ________________ Changes: ☐ YES ☐ NO Tech: ____
Changes: ____

____

____

7. Date reviewed and updated: ________________ Changes: ☐ YES ☐ NO Tech: ____
Changes: ____

____

____

8. Date reviewed and updated: ________________ Changes: ☐ YES ☐ NO Tech: ____
Changes: ____

____

____

9. Date reviewed and updated: ________________ Changes: ☐ YES ☐ NO Tech: ____
Changes: ____

____

____

10. Date reviewed and updated: ________________ Changes: ☐ YES ☐ NO Tech: ____
Changes: ____

____

____