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Welcome to our office! Today's Date_____

Last Name:_____First Name_____MI_____Preferred Name_____
Address_____City_____State_____Zip_____
Home Phone_____Cell Phone_____Work Phone_____
Email_____SSN_____
Date of Birth_____ Sex: M/F Occupation_____Employer_____
Emergency Contact Name_____Phone Number_____
Children (Name/Ages)_____
Date of Last Eye Exam_____How did you hear about our office?_____
Primary reason for today's visit:_____

INSURANCE INFORMATION
Vision_____ Member/ID_____ DOB_____
Secondary_____Member/ID_____ DOB_____
Medical_____Member/ID_____ DOB_____
Secondary_____Member/ID_____ DOB_____

MEDICAL INFORMATION
How is your general health?_____
Do you take medications for any of these systems? (Please circle all that apply.)

Gastrointestinal	Nervous	Endocrine (glands)
Ears/Nose/Throat	Urinary	Blood/Lymph
Cardiovascular	Muscles/Bones	Allergic/Immunologic
Respiratory	Integumentary(skin)	Headaches
High blood pressure	Eyes	Mental

Please explain_____
Do you have diabetes? Yes/No Type_____Date of diagnosis_____
Allergies to medication? Yes/No Which?_____Reactions_____
Other health problems?_____
Current medications (Names/Dosages)_____
_____
Have you had any surgeries? Yes/No Kind?_____When?_____
Name of family doctor and/or primary care physician:_____
Date of last visit:_____Date your blood pressure was last checked/results?_____

FAMILY HISTORY (Please circle all that apply and indicate relation to self.)

High blood pressure	Relation_____	Macular Degeneration	Relation_____
Diabetes	Relation_____	Retinal Detachment	Relation_____
Glaucoma	Relation_____	Cataracts	Relation_____

PERSONAL EYE INFORMATION
Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye surgeries? Yes/No Type_____Date_____
Have you had an eye injury? Yes/No Kind_____Date_____
Do you have any of the following conditions? (Please circle all that apply.)
Glaucoma Cataracts Macular Degeneration Retinal Detachment Dry Eyes Blurred vision
Do you wear glasses? Yes/No When? Distance Computer Near
Do you wear contact lenses? Yes/No Type_____
Are your contact lenses comfortable to wear all day? Yes/No Average daily wear time_____
Additional information_____