Name_____ Nickname_____ Cell phone_____
Address_____ Home phone_____
City_____ State_____ Zip_____ Work phone_____
DOB_____ Age_____ SS#_____ Occupation_____
Email address_____ Referred by_____

Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Widowed Relationship to insured: ☐ Self ☐ Spouse ☐ Child

Person responsible for account _____ relationship _____
Date of Birth of person responsible for account _____
Primary Insurance_____ ID#_____ Group # _____
Secondary Insurance _____ ID#_____ Group # _____

Briefly explain the primary reason for your visit today:_____

_____

MEDICAL, FAMILY & SOCIAL HISTORY: (Please indicate if you or any of your family members has had any of the following:

	Self	Family	Relationship to you
AIDS/HIV	☐	☐	_____
Allergies	☐	☐	_____
Anemia	☐	☐	_____
Arthritis-type_____	☐	☐	_____
Cancer	☐	☐	_____
Chronic Cough	☐	☐	_____
Constipation	☐	☐	_____
Convulsions / Seizures	☐	☐	_____
Depression	☐	☐	_____
Diabetes	☐	☐	_____
Diarrhea	☐	☐	_____
Dry Throat / Mouth	☐	☐	_____
Emphysema	☐	☐	_____
Heart condition	☐	☐	_____
Hepatitis	☐	☐	_____
High blood pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Kidney disease	☐	☐	_____
Lung disease / Asthma	☐	☐	_____
Lupus	☐	☐	_____
Migraine Headaches	☐	☐	_____
Sinus Congestion	☐	☐	_____
Skin conditions	☐	☐	_____
Stroke/paralysis	☐	☐	_____
Thyroid condition	☐	☐	_____

EYE CONDITIONS:	Self	Family	Relationship to you
Blindness	☐	☐	_____
Cataracts	☐	☐	_____
Cancer of eye	☐	☐	_____
Color Deficiency	☐	☐	_____
Crossed eyes	☐	☐	_____
Eye Surgery	☐	☐	_____
Glaucoma	☐	☐	_____
Lazy eye	☐	☐	_____
Macular degeneration	☐	☐	_____
Night Blindness	☐	☐	_____
Optic nerve problem	☐	☐	_____
Retinal problem	☐	☐	_____

Do you use sun protection for your eyes? ☐ Yes ☐ No
Are you pregnant? (females only) ☐ Yes ☐ No Due Date_____
Do you smoke? ☐ Yes ☐ No How much_____
Do you drink alcohol? ☐ Yes ☐ No How often_____
Do you use recreation drugs? ☐ Yes ☐ No Type_____

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
Date of last eye exam: _____ From Dr._____
Age of glasses:_____
Do you use a computer? ☐ Yes ☐ No Hours per day_____
Do you wear contacts? ☐ Yes ☐ No How old?_____
Type? ☐ disposable ☐ RGP ☐ soft ☐ toric Hours per day_____
Solution type_____

EYE PROBLEMS: Please check those visual symptoms that you have experienced recently:

☐ Blurred vision
☐ Burning eyes
☐ Discharge
☐ Dizziness
☐ Double Vision
☐ Dry eyes
☐ Eye Strain
☐ Floaters or Spots
☐ Foreign body sensation
☐ Glare
☐ Headaches
☐ Itching
☐ Loss of vision
☐ Pain
☐ Redness
☐ Seeing Flashes
☐ Tearing
☐ Tired Eyes

MEDICATIONS: List current medications, including eye drops.

_____

_____

ALLERGIES: List allergies to medications or other substances

_____

_____

Primary Care Physician name_____ Date of last physical_____

AUTHORIZATION:

I, the undersigned certify that I (or my dependent) have insurance with the above named Insurance company and assign direct to the attending Doctor of Optometry all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature:_____ ***Relationship:***_____ ***Date:***_____