Insurances:
Vision_____

Medical_____

Jackson and Lujan EYE CARE CENTER

*******For office use only*******
Doctor Reviewed_____

Date Reviewed_____

Patient's Name_____Patient's Birth Date_____

Mailing Address_____
(City) (State) **(Zip Code)**

Cell Phone_____Home Phone_____Work Phone_____

Employer/School_____Occupation_____

E-mail address _____Previous Patient?(circle one) Yes No

How did you find out about our office?_____

Parent/Guardian (if patient is a minor)_____Relationship to Patient_____

Preferred method of contact?(circle one) Home Work Cell Text E-mail

All glasses and contact orders will be notified by text/email unless you opt out by circling: Opt Out

Reason for visit today: (circle all that apply) Glasses Contacts Infection/injury

I would like information on laser vision correction or LASIK: (circle one) Yes No

Eye History:

If not with us, date of last eye exam?_____

Do you wear glasses? Yes No Do you wear contacts? Yes No

If contacts, what brand_____Contacts worn how many hours a day?_____

Do you sleep in contacts? Yes No If yes, how often?_____

How often do you change out your contact lenses? (circle one)

Weekly Every 2 weeks Monthly Yearly Other_____

Contact lens cleaning solution used: _____

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PLEASE TURN OVER AND SIGN THE BACK PORTION; IF YOU ARE A NEW PATIENT OR HAVE CHANGES TO YOUR MEDICAL HISTORY, PLEASE FILL OUT ENTIRE PATIENT INFORMATION

Medical History:
Are you pregnant or nursing at this time? Y N

Name of Medical Doctor:_____ Last physical_____

List any **medications** you are currently taking (including eye drops and over-the-counter)_____

_____

Are you **allergic to any medications**? Yes No If yes, please list_____

Please circle any symptoms or conditions that you may have:

Eye: Pain/soreness Glare/light sensitivity Dry/gritty Redness Burning Itching
Eye watering Chronic infections Tired eyes Mucous Squinting Double vision
Loss of vision Halos around lights Flashes Floaters Blurred vision Eye injury
Glaucoma Macular Degeneration Cataract
Eye surgery If yes, what type and date of surgery_____

Systemic: **None**
Weight loss/gain High blood pressure Fever Skin rash Headaches Numbness
Thyroid disorder High cholesterol Stroke Paralysis Diabetes Dry mouth
Sinus congestion Seasonal allergies Asthma Emphysema Acid reflux Hearing loss
Chronic bronchitis Vascular disease Cancer Arthritis Bleeding Kidney disease
Intestinal problems Muscle/Joint pain Anxiety Anemia Lupus Frequent urination
Bladder problems Rheumatoid arthritis Migraines Depression Heart disease Liver/spleen
Other_____

Family History: (circle all that apply) Diabetes High Blood Pressure
Blindness Glaucoma Cataracts Macular Degeneration Retinal Detachment

Social History: This information is kept strictly confidential. However, you may discuss it directly with the doctor if you prefer.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No
Do you use tobacco products? Yes No If yes, what type/amount/for how long_____
Do you drink alcohol? Yes No If yes, what type/amount/for how long_____
Do you use illegal drugs? Yes No If yes, what type/amount/for how long_____
Have you ever been exposed to or infected with any sexually transmitted disease? Yes No

_____ _____

Signature of Patient or Guardian if a minor **Date**