Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. **Patient ID:**

Last Name | Middle | First Name | Suffix | Preferred | DOB (mm/dd/yy) | SSN

Patient's Address | **Address Line 2** | Primary Phone ☐ Home ☐ Mobile | Day/Work Phone

City | State | Zip | Country | Emergency Contact | Emergency Phone

Email | Person responsible for this A/C

Sex ☐ Male ☐ Female ☐ Other | **Marital Status** ☐ Single ☐ Married ☐ Other | **Occupation**

How were you referred to our office ? | **Recreation/Hobbies:**

Referring Physician

☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D.

First Name | Middle | Last Name | Suffix | Clinic Name | ☐ Is Primary Care Physician

Clinic Address | City | State | Zip | Phone

Health History

Reason for today's exam

When was your last exam? | When was your last health exam?

Past illnesses or injuries

Past surgeries

Current eye drops

Current medications

Reactions/sensitivities medicines

Specific allergies

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Medical History

Diabetes	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Pregnant	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No	Nursing	☐ Yes ☐ No

Current Eye Symptoms

Glare/Light Sensitivity	☐ Yes ☐ No	Itching	☐ Yes ☐ No	Flashes	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Blurred Vision Distance	☐ Yes ☐ No	Floaters or Spots	☐ Yes ☐ No
Dryness/Burning	☐ Yes ☐ No	Blurred Vision Near	☐ Yes ☐ No	Fluctuating Vision	☐ Yes ☐ No
Excess Tearing/Watering	☐ Yes ☐ No	Double Vision	☐ Yes ☐ No	Other	☐ Yes ☐ No

Eye History

Amblyopia (Lazy Eye)	☐ Yes ☐ No	Dry Eye Syndrome	☐ Yes ☐ No	PVD (Vitreous Detachment)	☐ Yes ☐ No
Infection of Eye or Lid	☐ Yes ☐ No	Eye Injuries	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Crossed Eyes	☐ Yes ☐ No
Color Blindness	☐ Yes ☐ No	Glaucoma Suspect	☐ Yes ☐ No	Keratoconus	☐ Yes ☐ No
Diabetic Retinopathy	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No	Other	☐ Yes ☐ No

Family History

Cataract(s)	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No

Spectacle Lens History

Do you use a computer? ☐ Yes ☐ No How many hours/day? Distance from Computer?

Do you drive? ☐ Yes ☐ No Mileage to work each way?

Do you have glare problems? ☐ Yes ☐ No

Problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since

Type of glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Trouble in the past with glasses? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No Are your sun glasses your current prescription? ☐ Yes ☐ No

Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)
☐ Safety glasses (gardening, woodworking, weld
☐ Occupational (mechanics, plumbers, pilots)
☐ Sports/Hobbies (racquet sports, motorcycle)

Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No Reason for stopping?

Do you currently wear contact lenses? ☐ Yes ☐ No Since

Type and brand of contact lenses How many days/week?

How many hours/day? Today's Wearing Time

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being Excellence

	Left	Right	What Solutions do you use?	
Lens comfort			Cleaner	
Distance vision			Disinfectant	
Near vision			Enzyme	