

Today's Date _____

Patient Name _____ Age _____ Birthdate _____

Address _____ Home phone _____

City _____ State _____ Zip _____ Business phone _____

Employer _____ Address _____

How did you hear about us? _____

Who is your current eye doctor? _____

When was your last eye exam? _____

If child: Father's name _____

Father's employer _____

Father's business phone _____

Mother's name _____

Mother's employer _____

Mother's business phone _____

If married: Spouse's name _____

Spouse's employer _____

Spouse's business phone _____

Do you have Medicare? _____ Medicare # _____

Do you have Medical Assistance? _____

Other Ins. Co. Name _____

Group # _____ Agreement # _____

Patient Social Security # _____

Name, address & phone of your medical doctor _____

When was your last change in eyeglasses or contacts? _____

What doctor ordered the change? _____

What is your reason for your eye examination today? _____

routine exam _____ injury _____

problem _____ other, please explain _____

In case of an emergency:

Name _____ Relationship _____ Phone# _____

To what MEDICINES are you ALLERGIC? () Penicillin () Sulfa () Steroids

() Aspirin () Other-List Them _____

Are you Allergic to any EYE DROPS? () Yes () No If yes, Identify _____

Please check YES or NO for the following:

- | | | | | |
|---------------------------------------|--------------------------|--------------------------|--------------------|---|
| 1. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 2. High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 3. Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 4. Cancer | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 5. Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 6. Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 7. Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 8. Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Had Surgery? _____ | Which Eye? _____ When? _____ |
| | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Surgery? _____ When? _____
Intraocular Lens Implant? _____ |
| 9. Do you wear contacts? _____ | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Hard _____ Soft _____ Ex. Wear _____ |
| 10. Taking Birth Control Pills? _____ | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Medication _____ |
| 11. Have Lazy Eye(Amblyopia) _____ | <input type="checkbox"/> | <input type="checkbox"/> | How Long? _____ | Which Eye? _____ |
- Is there a family history of any of the above diseases? _____ Which? _____
- List any medical conditions you have _____
- What other medicines do you take? _____
- Have you ever had an eye examination? _____ Date of last exam _____
- Name and address of examiner _____
- Do you use eye drops? _____ Please List _____
- Have you ever been hit in the eye? _____ When? _____ Which Eye? _____
- What eye surgery have you had? _____
- Are you or have you ever been cross eyed? _____ Wall-eyed? _____

Signature of Patient

Date

Signature of Responsible Party

Date