Welcome!

To help us assist you, please complete the following information.

Your Name____ Date _______________

☐ Mr. ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Miss Date of Birth _____/_____/_____ Age ______

Address ____ Apt. # ______________________

City _________________________ State ___________ Zip __________________________

Home Phone (_______) _______________ Work Phone (_______) _______________

Social Security Number _________ /_________ /_________ Cell/Pager (______) ______________

How did you learn of our office? ____

Please list any family members who are patients in this office.

____

Occupation _________________________ Employer/School ______________________

Parent's name (if patient is a child) ____

Please list any active medical eye conditions. List any prescription or over the counter medications that you routinely use for your eyes.

____

Please list any past eye injuries, eye diseases, eye surgeries, or vision training.

____

Have you ever worn glasses?	☐ Yes	☐ No
Do you presently wear glasses?	☐ Yes	☐ No
Have you ever worn contact lenses?	☐ Yes	☐ No
Do you presently wear contact lenses?	☐ Yes	☐ No
Have you ever thought of wearing contact lenses?	☐ Yes	☐ No
Are you interested in laser vision correction?	☐ Yes	☐ No
Do you presently use a computer?	☐ Yes	☐ No

Please list your favorite hobbies and athletic activities, such as boating, tennis, golf, computers, gardening, woodworking or crafts.

____

MEDICAL HISTORY QUESTIONNAIRE

List any **medications** you currently take (prescription and over-the-counter); including vitamins/supplements: ____

____

Do you have any **allergies** to any medications? ☐ YES ☐ NO

If YES, list the medications: ____

List all **major illnesses** (diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

____

____

List any **surgeries** you have had (tonsillectomy, appendectomy): ____________________________

____

(over)

Do you ***currently*** have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
GENERAL / CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EAR, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent (indicate whether maternal or paternal)

DISEASE	YES	NO	Explanation of Problem
Arthritis			
Kidney disease			
Lupus			
Stroke			
Other			

SOCIAL HISTORY

Marital Status (married, divorced, single, widowed): ______________________

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3 /day 4+ /day

Do you smoke? ☐ YES ☐ NO If YES: occasional 1/2 pack per day 1 pack /day 1+ /day

Have you ever had a blood transfusion? ☐ YES ☐ NO

I understand that payment is required when services are rendered.

Signature ______________________

Method of Payment: ☐ Cash ☐ Check ☐ Visa/Mastercard

We Appreciate the Opportunity to Serve You.

History Reviewed. ☐ No Changes. ☐ Additions as noted above.

Physician's Signature ______________________