

WELCOME TO OUR OFFICE

Patient's Name: _____ Today's date: _____ ID #: _____

(If child parent's full names): _____ Date of Birth: _____ Age: _____

Address: _____ Main Telephone #: _____

City: _____ State: _____ Zip: _____ Work Telephone#: _____

Occupation: _____ E-mail address: _____

Vision Insurance Coverage? (Circle one) Yes No Name of Plan: _____

Employer: _____ Member's Name: _____ Relationship to patient: _____

Employer telephone #: _____ Insured ID #: _____

Patient's Ocular History: Date of Last eye exam? _____ Previous doctor's name: _____ Natural eye color: _____

Reason for today's visit? _____

Eyeglass wearer? Yes No For what purpose? _____ Do you use a computer? Yes No If so, how many hours per day? _____

Contact Lens wearer? Yes No If not, are you interested in contact lenses? Yes No

Have you ever had any Eye surgery ? Yes No Explain reasons/date: _____

Recent injury or trama to eyes? Yes No Explain reason/date: _____

Health Information: Do you have any allergies (medication/environmental/seasonal)? Explain: _____

	You	Family		You	Family		You	Family
Heart Disease	O	O	Glaucoma	O	O	Blindness	O	O
High Blood Pressure	O	O	Anxiety or Depression	O	O	Stroke	O	O
Cataracts	O	O	Asthma	O	O	Headaches	O	O
Retinal Detachment	O	O	ADD/ADHD	O	O	Lung Disease	O	O
Lazy eye	O	O	Diabetes	O	O	Dry Eyes	O	O
Color vision defiance	O	O	Stroke	O	O	Double vision	O	O
Cancer	O	O	Seisures/Epilepsy	O	O	Blood disorder	O	O
Hormone Dysfunction	O	O	High Cholesterol	O	O	Intestinal disease	O	O
Arthritis	O	O	Floaters	O	O	Thyroid Disorder	O	O

List the medications you take on a regular basis: _____

If you use Tobacco please circle choice: Cigarettes Pipe Cigar Chew Usage?: _____ Alcohol use? Yes No How often? _____

Dilation of the eyes is preformed as part of your eye health exam. It will cause you to be sensitive to bright lights and have blurred vision at close for a few hours. Driving may be difficult and should be done with caution. We will provide you with disposable sunglass protection before you leave our office if you do not have a pair. Please check appropriate bubble and sign below. _____ I agree to have my eyes dilated today _____ I would like to have my eyes dilated at another time

_____ I do not want my eyes dilated Patient signature: _____ today's date: _____