Patient Information

Today's Date: ______________________

Name: ______________________ Social Security No: ______________________

Address: ______________________

City: ______________ State: ________ Zip: __________ ☐ Male ☐ Female

Date of Birth: ______________ Phone No: ______________ ☐ Home ☐ Cell ☐ Work

If patient is a minor, Name of Parent/Guardian: ______________________

Email Address: ______________________

Occupation: ______________________ Employer: ______________________

Emergency Contact: ______________________ Phone No: ______________________

Reason for Visit: ______________________

Whom may we thank for referring you to our office? ______________________

Insurance Information

Policy Holder Name: ______________________

Policy Holder Date of Birth: ______________ Policy Holder Employer: ______________

Medical Insurance Provider: ______________________

Do you have vision insurance? ☐ Yes ☐ No Name of Insurance: ______________________

Basic Medical Information

Previous Eye Doctor's Name: ______________________ Date of Last Exam: ______________

Are you wearing contact lenses *right now?* ☐ Yes ☐ No If no, do you ever wear contact lenses? ☐ Yes ☐ No

Approximately how many hours per day do you spend on a computer/tablet? ______________

Primary Care Physician's Name: ______________________ Date of Last Exam: ______________

Height: __________ Weight: __________ Blood Pressure: ______________ Pulse: __________

List any medications or supplements you are currently taking: ______________________

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List any allergies to medications or other substances: ______________________

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Medical History Information

Have you been experiencing any of the following? Please mark all that apply.

☐ Pain ☐ Ocular Injury ☐ Blurry Vision ☐ Double Vision ☐ Eyestrain
☐ Redness ☐ Flashes ☐ Watering ☐ Itching ☐ Burning
☐ Headaches ☐ Floaters ☐ Dryness ☐ Loss of Vision

Have you ever had surgery on your eyes? ☐ Yes ☐ No If so, what procedure and which eye(s)? ____________

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Do you or any family members have history of any of the following diseases? Please mark all that apply; if it is a family member, please list the relationship.

Disease	Me	Family Member		Disease	Me	Family Member
Diabetes				Cataracts		
Macular Degeneration				Blindness		
Glaucoma				Crossed Eyes		
Retinal Detachment				Heart Disease		
High Blood Pressure				Cancer		
Thyroid Disease				Kidney Disease		

Have you experienced issues with any of these systems? Please mark all that apply.

☐ Gastrointestinal ☐ Nervous System ☐ Neurological ☐ Endocrine (Glands) ☐ Surgeries
☐ Ear/Nose/Throat ☐ Respiratory ☐ Headaches ☐ Genitourinary ☐ Skin
☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/Lymph ☐ Allergic/Immunologic

If you marked surgeries, what procedure did you have and when? ____________________________

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Do you use tobacco products? ☐ Yes ☐ No If yes, how frequently? ____________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how frequently? ____________________________

Do you use other substances? ☐ Yes ☐ No If yes, what substances and how frequently? ______________

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I have reviewed all of the above information and acknowledge that it is accurate and complete to the best of my knowledge.

Signature: ____