Welcome to our office! Thank you for trusting us with your eyecare and vision needs! If there are no changes since the last visit please write same.

Name:Dr.Mr.Mrs.Ms._____Preferred/Nick Name_____Date of Birth: _____

Address: _____ Home Phone: _____

City: _____State _____ Zip _____Cell Phone: _____

Occupation/Employer _____ Hobbies: _____

Spouse/Parent/Guardian _____ Family Dr. Name/Phone # _____

Responsible Party (Policy Holder) _____ **Policy Holder DOB** _____

Insurance Company _____**Policy Holder SS #** _____

FAMILY AND PERSONAL HISTORY

Glasses Worn:

- O Do not wear
- O Distance/Driving Only
- O Near/Reading Only
- O Full time

Age of Current Glasses _____

Contact Lenses worn:

- O Do not Wear
- O Daily Wear
- O Extended Wear
- O I would like to try Contacts

I replace my contacts every_____

Reason for today's Visit _____

Referred by _____

Examining Dr/Location _____

Last Exam _____

Has anyone in your family been treated or diagnosed for any of the following conditions? Specify which family member(s)

- O Diabetes_____
- O Cataracts _____
- O Thyroid Problems_____
- O Color Blindness _____
- O Glaucoma _____
- O Heart Disease _____
- O Blindness _____
- O Cancer _____
- O High Blood Pressure_____
- O Macular Degeneration _____
- O Retinal Detachments _____

Have you ever been treated or diagnosed with any of the following conditions? Currently or Previously.

- O Diabetes
- O Cataracts
- O Macular Degeneration
- O Color Blindness
- O Migraines
- O Dry Eyes
- O Glaucoma
- O Retinal Detachments
- O Blindness
- O Lazy/Crossed Eye
- O Eye Surgery
- O Allergies/Hayfever
- O Arthritis
- O Heart Disease
- O High Blood Pressure
- O Elevated Cholesterol
- O Acid Reflux/Heartburn
- O Strokes
- O Eye Injury (trauma, metal) _____
- O Cancer? Type _____
- O Thyroid Problems
- O Asthma

Do you have any health problems not listed above? If so please list. _____

_____

List of Medications- both Prescription and Over the Counter

What eye drops do you use? _____

Are you allergic to any medications?_____

Do you Smoke? Never Some Days Every Day _____# Packs/day Former Smoker

Do you Drink Alcohol? Never Daily Rarely _____ # Drinks per week

Email Address: _____

We use your email address to send out appointment reminders and to log in to your "personal health record". Your email address is not given to anyone. This can be changed at any time. If you prefer not to be notified by email or text messages please check the circles below:

O Opt out of Email Reminders O Opt out of Text Message Reminders