PATIENT INFORMATION

Please check the information on this report for accuracy.
Make any necessary corrections and **FILL IN ANY MISSING INFORMATION.** Thank you!

Name:_____ Birth date: _____ Social Security #: _____-____-_____
Address: _____ City, State, Zip: _____
Home Phone: _____ Work Phone: _____ Marital Status: S M W D
Cell Phone: _____ e-mail address: _____
Occupation/Grade: _____ Employer/School: _____
Emergency contact name & phone: _____
Primary Insurance Co.: _____ Secondary Ins Co.: _____
Primary Insured/Relationship:_____ DOB: _____ Social Security #_____

There is an additional fee to evaluate your current contact lenses. This fee is usually not covered by your vision or managed care plan.

If you are a new patient to our practice, by whom were you referred? _____
May we use all of your contact numbers and addresses to stay in touch with you? Yes No
May we call you at work to confirm your appointment? Yes No

Have you ever been diagnosed or treated for the following?

Cataracts	_____	Glaucoma	_____	Macular Degeneration	_____
Retinal Detachment	_____	Iritis	_____	Lazy Eye	_____
Corneal Abrasion	_____	Eye Infection	_____	Eye Injury	_____
Other (please explain)	_____				

Do you currently have any problems in the following areas? Please circle your answers and list medications:

General (Fever, weight loss, etc.)	Yes	No	_____
Ears, Nose Throat (Sinus, ear infection, cough)	Yes	No	_____
Cardiovascular (Heart, high blood pressure)	Yes	No	_____
Respiratory (Asthma, emphysema, etc.)	Yes	No	_____
Genital, Kidney Bladder (Disease, infection)	Yes	No	_____
Muscles, Joints, Bones (Arthritis, muscle ache)	Yes	No	_____
Skin (Acne, warts, skin cancer, etc.)	Yes	No	_____
Neurological (MS, headaches, numbness, etc.)	Yes	No	_____
Psychiatric (Anxiety, depression, insomnia)	Yes	No	_____
Endocrine (Diabetes, hypothyroid, etc.)	Yes	No	_____
Blood/Lymph (Cholesterolemia, anemia, etc.)	Yes	No	_____
Allergic/Immunologic (Hay fever, lupus, etc.)	Yes	No	_____
Gastrointestinal (Heartburn, abdominal pain, etc)	Yes	No	_____

Family Physician: _____ Last Visit: _____ Reason: _____
Do you have any drug allergies? Yes ___ No ___ Please list: _____
Do you currently take any medications? Yes ___ No ___ Please list: _____

Do you currently take any eye medications? Yes ___ No ___ Please list: _____

Please list any surgeries you have had in the past 24 months: _____

Please list any chronic illnesses or injuries: _____

Please list the relationship of any family member with a history of:

Blindness	_____	High Blood Pressure	_____	Heart Disease	_____
Glaucoma	_____	Macular Degeneration	_____	Retinal Problems	_____
Cataracts	_____	Kidney Disease	_____	Diabetes	_____
Lazy Eye	_____	Thyroid	_____	Other:	_____

Do you have visual difficulty when driving?	Yes	No	Do you drink alcohol?	Yes	No
Do you have problems with night vision?	Yes	No	Do you use tobacco?	Yes	No
Are you pregnant or nursing?	Yes	No	Do you use illegal drugs?	Yes	No

Patient/Guardian Signature: _____ Date: _____