

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 _____