Welcome to our office

Dr.___Mrs.___
Patients Name Mr.___Ms.___ ______________________________ Today's Date ______________
Address ______________________________ City ______________ State_____Zip______________
E-mail Address ____
Date of Birth______________ SSN____________________ Phone (H) ______________
Occupation______________ Employer____________________ (W)______________
Employer's Address______________________________ (C) ______________
If Student: Grade______________________ School/College______________________
Insurance: Major Medical____________________ Vision Plan______________________
Approx. Date of Last Eye Exam____________ By________________ City______________
Referred by: ______________________________ Hobbies:______________________

Main Purpose of Today's Visit: ____
Do You feel your prescription needs changing at: Distance____________and/or Near______________
Are you interested in Laser Vision Correction? Yes________________ No______________
Do you use computers on a daily basis: __________ If yes, number of hours per day______________

Do you have, or is there any family history of (S = Self, F = Family)

_____ Glaucoma	_____ Eye Surgery	_____ Headaches
_____ Diabetes, if yes Type_____	_____ Eye/Head Injury	_____ Double Vision
_____ High blood pressure	_____ Blindness	_____ Flashes/Floaters
_____ Cataracts	_____ Sudden Vision Loss	_____ Arthritis

(OVER)

Do you have any problems with any of these systems? *(Please circle all that apply)*

Gastrointestinal	Y/N	Nervous	Y/N	Mental Health	Y/N
Ear/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (Glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Allergic/Immune	Y/N
Respiratory	Y/N	Blood/Lymph	Y/N	Integumentary (skin)	Y/N

Pleaseexplain______________________________

Do you have difficulty driving at night? ____________________

Are you presently taking any medications (I.E. high Blood pressure, birth control pills, vitamins, etc)

If so, please list and state for what purpose: ____________________

____

____

Do you have allergies to any medications?____________________

Are you pregnant or nursing? ____________________

Do you use cigarettes/tobacco?__________ Alcohol? __________ Other Substances? __________

If Yes, please list amount and how often: ____________________

Name of regular Physician:__________ City__________ Date of last exam __________

<u>Contact Lens History</u>

Have you ever worn contacts lenses?__________ If yes, what type?__________

Who prescribed them? __________ City __________

Do you Wear contact lenses now? __________ If not why did you quit?__________

____

When did you stop wearing them?____________________

What type of contact lenses are you interested in wearing?____________________

Doctor's Initials/Date