

PATIENT NAME: _____

AGE: _____ DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

RESPONSIBLE PARTY: (IF OTHER THAN PATIENT) _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

OCCUPATION OF PATIENT: _____ DATE OF LAST EYE EXAMINATION: _____

HOME PHONE: _____ WORK PHONE: _____

PREFERRED PAYMENT METHOD: CASH: _____ CHECK: _____ VISA: _____ MASTERCARD: _____ AMEX: _____

HMO/INSURANCE COVERAGE: _____

HOW DID YOU HEAR ABOUT THIS OFFICE: WORD OF MOUTH: _____ NEWSPAPER: _____ OTHER: _____

WHAT IS THE MAIN REASON OR PROBLEM THAT HAS CAUSED YOU TO COME IN TO SEE US TODAY?

PATIENT HISTORY: DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> CATARACT	<input type="checkbox"/> GLAUCOMA
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> DOUBLE VISION	<input type="checkbox"/> LAZY EYE
<input type="checkbox"/> DIABETES	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> EYE INJURY	<input type="checkbox"/> LIGHT SENSITIVITY
<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> THYROID DISORDER	<input type="checkbox"/> EYE SURGERY	<input type="checkbox"/> PINK EYE
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> EYES ITCH	<input type="checkbox"/> EYE TURN (IN OR OUT)
<input type="checkbox"/> GOUT	<input type="checkbox"/> ULCERS	<input type="checkbox"/> EYES TEAR	<input type="checkbox"/> RETINAL DISEASE
<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> CURRENT PREGNANCY	<input type="checkbox"/> EYES BURN	<input type="checkbox"/> VISUAL THERAPY

FAMILY HISTORY: HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING?

<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> CATARACTS
<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> LAZY EYE	<input type="checkbox"/> RETINAL DISEASE	<input type="checkbox"/> EYE TURN (IN OR OUT)

DO YOU HAVE FREQUENT HEADACHES? (IF SO, PLEASE DESCRIBE) _____

ARE YOU TAKING MEDICATIONS: PLEASE LIST: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST: _____

HAVE YOU WORN CONTACT LENSES? YES _____ NO _____

WHAT TYPE? _____ HOW LONG AGO? _____