PATIENT NAME: ______________________________ **DATE:** ______________

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: ______________ CELL PHONE: ______________

EMAIL ADDRESS: ______________________________

PRIMARY INSURANCE COVERAGE: ______________________________

MEMBER ID NUMBER: ______________________________

SECONDARY INSURANCE COVERAGE: ______________________________

MEMBER ID NUMBER: ______________________________

PRIMARY CARE PHYSICIAN: ______________________________

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?

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

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

___ DIABETES	___ HIGH BLOOD PRESSURE	___ TUBERCULOSIS	___ CATARACTS
___ GLAUCOMA	___ LAZY EYE	___ RETINAL DISEASE	___ 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? ______________