Name:____________________________

APPOINTMENT DATE: ________________

Primary Care Provider________________

Were you referred to our office? Yes ☐ No ☐

Do You Wear Glasses? Yes ☐ No ☐

Currently Wear Contacts? Yes ☐ No ☐

Reason for Today's Visit ________________

Current Medication: *☐None*

(Prescription and over the counter)

____

____

____

Medication Allergies:

____

Preferred Pharmacy:

Please check Yes or No:

Do you smoke tobacco ? Yes ☐ No ☐

Do you smoke marijuana? Yes ☐ No ☐

Do you drink alcohol ? Yes ☐ No ☐

Do you use other substances ? Yes ☐ No ☐

Are you currently experiencing? *☐None*

☐ Blurred Vision → ☐ Near ☐ Distance

○ WITH OR ○ WITHOUT CORRECTION

☐ Double Vision

○ WITH OR ○ WITHOUT CORRECTION

☐ Burning ☐ Itching

☐ Dryness ☐ Light Sensitivity

☐ Headache ☐ Sandy of gritty

☐ Redness ☐ Discharge

☐ Floaters or spots ☐ Loss of Vision

☐ Halos ☐ Pain

☐ Light Flashes ☐ Excess tearing

Have you experienced, or been treated for the following? *☐None*

☐ Cataracts

☐ Glaucoma ☐ Allergies

☐ Macular Degeneration ☐ Arthritis

☐ Retinal Detachment ☐ Asthma

☐ Diabetes ☐ Lupus

☐ High Blood Pressure ☐ Stroke

☐ Heart Disease ☐ Seizures

☐ High Cholesterol ☐ Ear, Nose Throat Conditions

☐ Kidney Disease

☐ Psychiatric Disorders ☐ Liver Disease

☐ Thyroid Dysfunction ☐ Cancer

☐ Blood/Lymph Disorder

☐ Gastrointestinal Conditions

We respect your right to privacy. The questions on this page are used strictly for your Health information, and billing purposes.

Please be thorough when filling out this form.

Family Ocular History:

☐ Adopted- Unknown

☐ Blindness

Who:________________

☐ Cataract

Who:________________

☐ Color Deficiency

Who:________________

☐ Dry Eye

Who:________________

☐ Glaucoma

Who:________________

☐ Macular Degeneration

Who:________________

☐ Retinal Detachment

Who:________________

Dry Eye

1. Do your eyes ever feel dry or uncomfortable? ☐ Yes ☐ No
2. Are you bothered by changes in your vision throughout the day? ☐ Yes ☐ No
3. Are you ever bothered by red eyes? ☐ Yes ☐ No
4. Do you ever use or feel the need to use drops? ☐ Yes ☐ No

Surgical History: *☐None*

Ocular:________________

____

Other:________________

____

Employer:________________

Occupation:________________

☐ **Retired** ☐ **Student**

Race: (check all that apply)

☐ Alaska Native

☐ Asian

☐ African American

☐ Hispanic

☐ Pacific Islander

☐ White

☐ Decline to Specify

Preferred Language:____________

Communication Preference:

☐ Postal

☐ Telephone/TEXT

☐ E-Mail

____

OK TO TEXT? ☐Yes ☐No

OK TO EMAIL? ☐Yes ☐No

We will only message you for reminders of appointments and/or when your glasses or contact lenses are ready for pick-up

The following information is for insurance purposes only:

Marital Status:

☐ Single

☐ Married ⇨ Spouse Name:________________

☐ Divorced Spouse's Date of Birth:________________

☐ Widowed ☐ Working ☐ Retired

☐ Other Spouse's Employer:________________

Who is responsible for this patient? ***☐SELF ☐Parent ☐Other***

Name:________________ DOB:__________ Relationship:__________

Address:________________ Phone:____________

Name:________________ DOB:__________ Relationship:__________

Address:________________ Phone:____________