PATIENT INFORMATION

EXAM DATE: ___ / ___ / ___

LAST NAME ______________________ FIRST NAME ______________________ ☐ M ☐ F BIRTH DATE ___ / ___ / ___

ADDRESS ______________________ CITY ______________________ STATE / PROVINCE ________ ZIP / POSTAL CODE ________

HOME PHONE ( ) ______________ WORK PHONE ( ) ______________ CELL PHONE ( ) ______________

EMPLOYER ______________________ OCCUPATION ______________________

REFERRED BY ______________ EMAIL ADDRESS ______________ SIGNATURE ______________

INSURANCE INFORMATION

PLAN NAME ______________________ GROUP ______________

INSURED NAME ______________________ RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD (CHECK ONE)

INSURED ID# ______________ INSURED DATE OF BIRTH ___ / ___ / ___ **LAST 4 of SS#**____________

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM? ______________________

____

____

ARE YOU PLANNING TO GET NEW GLASSES TODAY? YES ☐ NO ☐

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? YES ☐ NO ☐

AGE OF PRESENT GLASSES ______ AGE OF SUNGLASSES ______ DATE OF LAST EYE EXAM ___ / ___ / ___ FROM DR. ______________ PREVIOUS PATIENT? ☐ YES ☐ NO

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	☐	☐	☐	GLAUCOMA	☐	☐	☐	DO YOU SEE DOUBLE?	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐	FREQUENT HEADACHES?	☐	☐
THYROID PROBLEMS	☐	☐	☐	RETINAL DISEASE	☐	☐	☐	ARE YOU PREGNANT?	☐	☐
HEART DISEASE	☐	☐	☐	EYE SURGERY	☐	☐	☐	EYES BEEN DILATED?	☐	☐ YEAR? ______
ASTHMA	☐	☐	☐	EYE INJURY	☐	☐	☐	PRIMARY CARE DR. ______________		
CANCER	☐	☐	☐	OTHER ______	☐	☐	☐			

PLEASE EXPLAIN ANY POSITIVE FINDINGS: ______________________

____

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. ______________________

____

____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST. ______________________

____

____

____

DO YOU HAVE ANY ALLERGIES, MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN. ______________________

____

____

____

Preferred Contact (Please Circle One)

Text Message Work Phone E-mail

Home Phone Cell Phone

PROCEED TO CONSULTATIVE Rx FORM