HEALTH HISTORY

Name _____ Age _____

Reason for today's exam _____

_____

Date of last exam _____ Name of eye doctor _____

Do you or anyone in your immediate family have a history of the following?

- ☐ Diabetes
- ☐ Blindness
- ☐ High blood pressure
- ☐ Cataracts
- ☐ Thyroid
- ☐ Turned or lazy eye
- ☐ Glaucoma
- ☐ Heart condition

Please check any of the following conditions that apply to you:

- ☐ Frequent headaches
- ☐ Drug allergies
- ☐ Pregnant
- ☐ Allergies
- ☐ Sinus trouble
- ☐ Have given birth in the last 6 months

Please list all medications you are currently taking: _____

Have you ever had any of the following conditions involving your eyes?

- ☐ Eye surgery
- ☐ Sensitivity to light
- ☐ Eye infection or disease
- ☐ Eye injury
- ☐ Floaters or spots
- ☐ Double vision
- ☐ Medical treatment
- ☐ Poor distance vision
- ☐ Eye strain
- ☐ Severe pain
- ☐ Poor near vision
- ☐ Eyes burn, itch, or water

Do you currently wear glasses? ☐ Yes ☐ No

When do you wear your glasses?

- ☐ All the time
- ☐ Reading/near work
- ☐ Work safety
- ☐ Distance tasks only
- ☐ Computer work
- ☐ Other, please explain _____

Have you ever worn contacts? ☐ Yes ☐ No

Are you interested in wearing contact lenses? ☐ Yes ☐ No

If so, what style?

- ☐ Soft
- ☐ Extended Wear
- ☐ Gas Permeable
- ☐ Bifocal
- ☐ Tinted
- ☐ Astigmatic
- ☐ Disposable
- ☐ Unsure

Do you work at a computer or video display terminal? ☐ Yes ☐ No

What hobbies or sports do you participate in? _____

X _____

SIGNATURE OF PATIENT (Or parent if a minor) DATE

CONFIDENTIAL

PATIENT INFORMATION

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name _____ Date _____ Patient No. _____
First MI Last

Address _____ City _____ State _____ Zip _____

Birthdate _____ phone # _____ email: _____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Either

Are You: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Workplace _____ Work phone # _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

RESPONSIBLE PARTY

Name of person responsible for this account _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ No ☐ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____