

PATIENT INFORMATION

EXAM DATE: / /

LAST NAME _____ FIRST NAME _____ M F BIRTH DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____
EMPLOYER _____ OCCUPATION _____ HOBBY _____
REFERRED BY _____ EMAIL _____ SIGNATURE _____

INSURANCE INFORMATION

PLAN NAME _____ GROUP _____
INSURED NAME _____ RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD (CHECK ONE)
INSURED ID# _____ INSURED DATE OF BIRTH _____

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(IE. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SEE DOUBLE?	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT HEADACHES?	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYES BEEN DILATED?	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IF YES	YEAR?	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRIMARY CARE DR.	_____	_____

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. _____

PROCEED TO CONSULTATIVE Rx FORM