Welcome to our office!

PATIENT INFORMATION

Please Print

Patient Name: Mr / Mrs / Ms / Miss / Dr ______________________________ Nickname:_________________________
Gender: Male / Female (please circle) Date Of Birth:________________________ Age:__________
Address: ____ City:____________________ State:____ Zip Code:______
Home Phone:(____) _______________Work Phone:(____) ________________Cell Phone:(____) _______________
E-mail: ____ Social Security #: ______________________________
Vision Insurance: _____________________________________ Medical Insurance:_____________________________
Occupation:____ Employment Status:____________________________
If Student, Grade: ____________________________________ Hobbies:______________________________________
Marital Status (Optional):_____________ Ethnicity (Optional):____________________ Race (Optional):_____________
Preferred Language (Optional):__________________________ Referred By:__________________________________

Reason For Your Visit Today?____

When was your **Last Eye Exam**? ______________________ **Last Medical Exam**? ___________________________
Do you wear **glasses**? Yes No
Do you wear **contact lenses**? Yes No * *If yes*, what type? Soft / RGP / Toric (Astigmatism) / Extended *(please circle)*
Brand/Name?_____________________________________
* *If no*, are you interested in wearing contact lenses? Yes No

Have you ever had any **eye disease, injury, or surgery**? Yes No *If yes*, please explain:_______________________
____

What are your **main ocular difficulties**? PLEASE CHECK ALL THAT APPLY.

Blur at DISTANCE _______	Blur at NEAR ______	Double Vision _____	Poor Night Vision _____________
Eyestrain _______________	Glare _____________	Headaches ________	Loss Of Vision________________
Itching _________________	Tearing ___________	Burning __________	Redness ______________________
Ocular Pain _____________	Flashes of Light ____	Floaters __________	Light Sensitivity ______________

Are you currently taking any **medications**? *If yes*, please list all medications that you are taking:
____
____

Do you have any **allergies**? Yes No *If yes*, please list all medical, environmental, or food allergies:
____
____

Are you **pregnant or nursing**? Yes No

Have you or family members ever been diagnosed with any of the following? *If yes*, state relationship. *If no*, leave blank.

Glaucoma? ____	Hepatitis? ____
Cataracts? ____	HIV/AIDS? ____
Retinal Disease? What type?___________________________	Cancer? What type?_______________________________________
Macular Degeneration? ________________________________	Skin Disease? What type?___________________________________
High Blood Pressure? _________________________________	Thyroid Disease?____
Diabetes? ____	Asthma?____
Heart Disease? _____________________________________	Other Disease Not Listed?___________________________________

DILATION OF THE PUPIL involves instilling eye drops to temporarily enlarge the pupils. This allows the doctor to check the health of the posterior segment of the eyes, assisting in the early detection of many disorders (including Glaucoma, Cataracts, Macular Degeneration, Hypertensive Retinopathy, Diabetic Retinopathy, and Cancer).

_____ I agree to have my eyes dilated today
_____ I refuse dilation today, but will reschedule
_____ I do NOT agree to have my eyes dilated

Signature ____________________________________ Date _______________________________________