PLEASE PRINT, FILL OUT AND BRING TO YOUR APPOINTMENT

# PATIENT INFORMATION SHEET

## About You

**PLEASE SILENCE YOUR CELL PHONE! THANKS!**

Today's Date _____

_____

Last Name First MI Mr Mrs Ms Dr

☐ Male ☐ Female I prefer to be called: _____

Birth Date: __ / __ / __ Age ___ SS#_____

Home Address_____

City _____ State _____ Zip _____

Home # _____ Pager/Cell # _____

Work # _____ Ext. ____DL#_____

E-mail _____

Employer (or school) _____

Occupation (or grade) _____

Spouse (or parents) _____

Whom may we thank for referring you?
Name_____ Relationship_____

If not referred, how did you choose our office?

☐ Another doctor ☐ Insurance List

☐ Saw Sign/Bldg. ☐ Newspaper/Radio/TV

☐ Yellow Pages ☐ Web Site (which?)_____

☐ Other _____

## Family Eye History

Is there a family history of any of the following?

| | Relationship |
|---|---|
| ☐ Blindness | _____ |
| ☐ Cataracts | _____ |
| ☐ Corneal Problems | _____ |
| ☐ Glaucoma | _____ |
| ☐ Macular Degeneration | _____ |
| ☐ Lazy or Crossed Eyes | _____ |
| ☐ Retinal Detachment | _____ |
| ☐ Other _____ | _____ |

## Family Medical History

Is there a family history of any of the following?

| | Relationship |
|---|---|
| ☐ Arthritis | _____ |
| ☐ Cancer | _____ |
| ☐ Diabetes | _____ |
| ☐ Heart Disease | _____ |
| ☐ High Blood Pressure | _____ |
| ☐ Kidney Disease | _____ |
| ☐ Lupus | _____ |
| ☐ Thyroid Disease | _____ |
| ☐ Other _____ | _____ |

## Insurance/Payment

Vision Insurance _____

Subscriber Name _____

Subscriber SS# _____ Birth Date __ /__ /__

Subscriber Employer _____

Relationship to Patient _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SS# _____ Birth Date __ /__ /__

Do you participate in a Flex Spending Acct.?_____

**PAYMENT POLICY:**

1) Payment for services, or insurance deductibles for services, is due at the time of service.
2) A deposit of at least 50% for materials is due at the time of ordering. The balance is due at the time of dispense.
3) We accept Cash, Check, Visa, and MasterCard.
4) We will direct bill, and accept payment from, certain insurance companies which have a positive record for payments. If we determine your insurance company has a poor track record for payments, then the fee for services must be paid at the time of service, and we will bill your insurance company for reimbursement to you.
5) Any amounts due which are not paid by your insurance company are your responsibility to pay.

I have read the above and agree to its contents.

Patient (or guardian) signature _____ Date _____

☐ Current Patients, please check here, sign and date, if there have been no changes in your history since last exam.

**PLEASE TURN OVER AND COMPLETE THE OTHER SIDE.**

# Patient Eye and Medical History

**Eye History**

What is the major purpose of this visit?

_____

_____

Date of last eye exam _____

By whom? _____

Have you ever worn contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

Which kind?_____ Wearing time/day?_____

Which solutions? _____

Are you interested in trying colored contact lenses to change your eye color? ☐ Yes ☐ No

Do you… ?

☐ Work at a computer?

☐ Think you'd benefit from thinner, lighter lenses?

☐ Have interest in a contact lens "Test Drive"?

☐ Spend time outdoors? (Approx. _____ hrs./wk.)

☐ Have prescription sunglasses?

☐ Prefer not to wear your glasses at times?

☐ Want information on Laser Vision Correction?

☐ Have interest in non-surgical vision correction?

☐ Need a back-up pair of prescription glasses?

☐ Have family members in need of eyecare?

☐ Wear bifocals in which the line bothers you?

☐ Have glare problems when driving at night?

**Social History** (This information is kept strictly confidential. However, you may discuss this directly with the doctor if you prefer.)

Do you use tobacco? ☐ Yes ☐ No

Type/amount/how long? _____

Do you drink alcohol? ☐ Yes ☐ No

Type/amount/how long? _____

Do you use non-prescription drugs? ☐ Yes ☐ No

Type, amount, how long? _____

**Medical History**

Name of family physician _____

City _____ Phone _____

Date of last physical exam _____

Current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Medications (Rx or over-the-counter)

(list names of medications, including eye drops, vitamins, and birth control pills)_____

_____

_____

_____

Allergies to medications? ☐ Yes ☐ No

_____

**Review of Systems**

Do you currently have, or have you ever had, any problems in the following areas?

Constitutional

☐ Fever, Weight loss/gain

Integumentary

☐ Skin problems

Neurological

☐ Headaches/Migraines ☐ Seizures

Eyes

☐ Loss of vision ☐ Blurred vision

☐ Distorted vision/halos ☐ Loss of side vision

☐ Double vision ☐ Dryness

☐ Mucous discharge ☐ Redness

☐ Sandy / gritty feeling ☐ Itchiness

☐ Burning ☐ Foreign body

☐ Excessive tearing ☐ Glare sensitivity

☐ Pain or soreness ☐ Lid infections

☐ Styes or chalazion ☐ Flashes / floaters

☐ Tired eyes ☐ Corneal abrasion

☐ Lazy eye ☐ Eye injury

☐ Retinal detachment ☐ Glaucoma

☐ Macular degeneration ☐ Cataracts

Endocrine

☐ Thyroid / Other glands

Ears, Nose, Mouth, Throat

☐ Allergies ☐ Sinus congestion

☐ Runny nose ☐ Post-nasal drip

☐ Chronic cough ☐ Dry throat/mouth

Respiratory

☐ Asthma ☐ Chronic bronchitis

☐ Emphysema

Vascular / Cardiovascular

☐ Diabetes ☐ Heart disease

☐ High blood pressure ☐ Vascular disease

Gastrointestinal

☐ Diarrhea ☐ Constipation

Genito-urinary

☐ Genitals / Kidney / Bladder problems

Bones / Joints / Muscles

☐ Rheumatoid arthritis ☐ Muscle pain

☐ Joint pain

Lymphatic / Hematologic

☐ Anemia ☐ Bleeding problems

Allergic / Immunologic

☐ Allergic reactions ☐ Immune problems

Psychiatric

☐ Psychiatric disorders