Eye Examination Form

MR. LAST NAME MRS. MS. DR. REV.	FIRST NAME & MIDDLE INITIAL	WHAT NAME WOULD YOU LIKE OUR STAFF TO CALL YOU?	DATE
ADDRESS	CITY	STATE & ZIP	E-MAIL ADDRESS *This information is kept private
PLACE OF EMPLOYMENT(or SCHOOL)	TYPE OF WORK (or GRADE)	DATE OF BIRTH & AGE	SOCIAL SECURITY NUMBER
IF MINOR, PARENT NAME	SPOUSE NAME	HOME TELEPHONE	WORK TELEPHONE May we contact you at work? Y / N

What is the major purpose of this visit?
____
____
Any problems with your present contact lenses or glasses?
____
____

VERY IMPORTANT! NEW PATIENTS ONLY:
Whom may we thank for referring you to our office?
Name of friend or relative: ________________________________

If not referred, how did you choose our office for your needs?
( ) Saw sign / building ( ) Yellow Pages
( ) Insurance List ( ) Another Dr. _______________
( ) Newspaper / Radio / TV (please circle)
( ) Web Pages: Which web site? ___________________________
( ) Other: ____

Most recent Rx if known

Contact Lenses:
(R) __________________________________
(L) ___________________________________
Brand:_______________________________
Eyeglasses Rx:
(R) __________________________________
(L) ___________________________________
Add _______________________________

Do you participate in a flex spending account? ( ) Yes ( ) No
How will you settle your account today? ( )cash ( )check ( )credit

FAMILY MEDICAL / EYE HISTORY (Check all that apply)

Is there a family medical history of any of the following?

		Relationship
Blindness	( )	___________________________
Cataracts	( )	___________________________
Corneal Problems	( )	___________________________
Glaucoma	( )	___________________________
Lazy Eye	( )	___________________________
Macular Degeneration	( )	___________________________
Diabetes	( )	___________________________
Heart Disease	( )	___________________________

PATIENT MEDICAL HISTORY

Name of Family Physician ___________________________
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills ____
____
Allergies to Medications : ( ) No ( ) Yes– Which?
____
Have you ever been diagnosed or treated for the following?
( ) Allergies ( ) Diabetes ( ) Thyroid
( ) Asthma ( ) Heart Disease ( ) Other:
( ) Arthritis ( ) High Blood Pressure
( ) Cancer ( ) Kidney
( ) Cholesterol ( ) Nerves

PATIENT EYE HISTORY

Date of Last Eye Exam _____________________________
By Whom? _____________________________________
Do you currently wear contact lenses? ( ) Yes ( ) No
What kind?____
Are you interested in contact lenses today? ( ) Yes ( ) No
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes?_________________

Do you…..(Check if your answer is Yes)
( ) Work at a computer? (How much) ____ hrs/week
( ) Spend time outdoors? (How much) ____ hrs/week
( ) Want information on Laser Vision Correction Surgery?

Have you ever been diagnosed or treated for the following?
( ) Cataracts ( ) Eye Surgery ( ) Macular Degeneration
( ) Corneal Abrasion ( ) Glaucoma ( ) Retinal Detachment
( ) Eye Infection ( ) Iritis/Uveitis ( ) Other Eye Disorders
( ) Eye Injury ( ) Lazy Eye

Do you experience or have you ever experienced?
( ) Blurry Vision ( ) Floaters / spots
( ) Burning ( ) Grittiness
( ) Tearing ( ) Itchiness
( ) Headaches ( ) Crossed eye / eye turn
( ) Double Vision ( ) Trouble seeing at night
( ) Flash of Light ( ) Bothered by Glare

I agree to be responsible for my bill and any necessary collections fees made necessary to collect payment of materials and/or services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize this office to release or obtain any required medical information from my attending physicians or any medical facility.

Patient's signature ____ Date ____________________________

***Please use reverse side is additional space is needed ———>