PATIENT INFORMATION: PLEASE PRINT Sex M F Marital Status: M S D W

Name _____ Birth Date _____ Age ____

Address _____ City _____ State _____ Zip _____

Home Tel. # _____ Work Tel.# _____ Cell/Alt # _____

*Check preferred telephone number to call Email: _____

Referred By: _____ Family Physician: _____

MEDICAL STATUS AND HISTORY

Complaint - Please state reason for today's visit: _____

_____

Symptoms - Please circle: Blurred Vision/Recent Change in Vision Double Vision Glare Difficulty Reading
Eye Pain Light Sensitivity Halos Tearing Mattering Redness Eyelid Crusting
Eyelid Swelling Eye Injury Flashes of Light Floaters or Spots Shadows in Vision

Are you using any eye medications? No Yes. If Yes, list: _____

Do you have any allergies to medication? No Yes. If Yes, list: _____

Previous eye history: Cataract / Glaucoma / Injury _____

Do you wear glasses / contacts? No Yes. _____ Contacts: Disposable / Daily / Gas Perm / Overnight Wear

Prior hospitalizations for: _____

General surgery for: _____

Medications being used: _____

_____

REVIEW OF SYSTEMS Do you have: Diabetes High Blood Pressure Asthma Arthritis Cancer Epilepsy
Migraine Heart Condition Thyroid Disease

Do you currently have any of the following problems:	Yes	No	If Yes, please explain:
Chronic fever, unexpected weight loss/gain fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g., chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems(e.g., heartburn, abdominal pain, diarrhea,vomiting)	☐	☐	
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g., rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

FAMILY/SOCIAL HISTORY Is there any family history of the following conditions? If Yes, circle:
Glaucoma Blindness Color Blindness Macular Degeneration Cataracts Crossed-Eyes Other Eye Disease
Diabetes High Blood Pressure Heart Disease Cancer Migraine Other _____

Do you smoke? No Yes. How much? _____ Drink alcohol? No Yes. How much? _____

Your Occupation: _____ Employed By: _____

Employer's Address _____ City _____ State ____ Zip _____

Person responsible for bill _____

INSURANCE INFORMATION ☐ PPO ☐ HMO ☐ Workman's Comp ☐ Other _____

(Only if we are a participant in your insurance plan will this office file.)

Do you have an insurance change since last visit? ☐ yes ☐ no

Insurance Company Name _____

I hereby authorize payment directly to the office for professional services rendered and I shall be personally responsible for any unpaid balance to the doctor. I hereby authorize the attending doctor to release any information concerning my examination or treatment.

_____

Insured Patient or Parent (if patient is a minor) Date