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: ______________________

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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: ______________________

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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.

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