

Welcome To Our Office

Name _____
 Street _____
 City _____ State _____ Zip _____
 Home Phone _____
 Work Phone _____
 E-Mail Address _____
 Employer (or School) _____
 Occupation _____

Today's Date _____ Last Eye Exam _____
 Former Vision Care Provider _____
 Date of Birth _____
 Sex M ___ F ___ Social Security # _____
 Spouse (or Parent's) Name _____
 Spouse (or Parent's) Work Phone _____
 Vision Insurance _____

Medical History

Eye Injury	No	Yes
Eye Surgery	No	Yes
Lazy Eye	No	Yes
Cataracts	No	Yes
Glaucoma	No	Yes
Arthritis	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
High Blood Pressure	No	Yes
Kidney	No	Yes
Other _____		

Family Medical History

Relationship (living or dead)
 Parents, Grandparents, Siblings, Children

Blindness	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Macular Degeneration	No	Yes	_____
High Blood Pressure	No	Yes	_____
Retinal Detachment	No	Yes	_____
Other _____			

Social History

Do You Use:

Cigarette/Tobacco	No	Yes
Alcohol	No	Yes
Home Assistance	No	Yes

Current Medications (Rx or Over the Counter)

Name of Medication

Antihistamines	No	Yes	_____
Diuretic (Water Pills)	No	Yes	_____
High Blood Prsr Pills	No	Yes	_____
Oral Contraceptives	No	Yes	_____
Sleeping Tablets	No	Yes	_____
Eye Drops	No	Yes	_____
Other _____			
Name of Medical Doctor _____			
Date of Last Medical Exam _____			

Medical Information

What is your general health? _____

Do you have problems with any of these systems?

Environmental Allergies	Yes	No	Gastrointestinal	Yes	No	Musculoskeletal	Yes	No
Allergic to what? _____			Ear/Nose/Throat	Yes	No	Integumentary (skin)	Yes	No
What happens? _____			Cardiovascular	Yes	No	Mental	Yes	No
Medication Allergies	Yes	No	Respiratory	Yes	No	Endocrine (glands)	Yes	No
Allergic to what? _____			Nervous	Yes	No	Blood/lymph	Yes	No
What happens? _____			Genitourinary	Yes	No	Allergic/immunologic	Yes	No

**If you are visiting our office for the first time:

How did you first hear about our office?

Referred by a friend or a relative
 If so, who? _____

Referred by another health care provider
 If so, who? _____

Yellow Pages
 Newspaper Advertisement
 Office Signage
 Other _____

What is the major purpose of this visit?

What do you like or dislike about your present glasses or contact lenses?

What other family members are our patients?

