

Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr.						Patient ID:	
Last Name	Middle	First Name	Suffix	Preferred	DOB (mm/dd/yy)	SSN	

Patient's Address		Address Line 2		Primary Phone <input type="checkbox"/> Home <input type="checkbox"/> Mobile	Day/Work Phone
City	State	Zip	Country	Emergency Contact	Emergency Phone
Email			Person responsible for this A/C		

Height <input type="text"/> ft <input type="text"/> in <input type="text"/> cm/m	Authorized to discuss health info Name <input type="text"/>
<input type="checkbox"/> ft in <input type="checkbox"/> cm <input type="checkbox"/> m	
Weight <input type="text"/> lbs <input type="text"/> kg	Relationship to patient <input type="text"/>

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Patient Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Student <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Employed <input type="checkbox"/>
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Gender Identity <input type="checkbox"/> Identifies as Male <input type="checkbox"/> Identifies as Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Transgender Female (Male to Female) <input type="checkbox"/> Neither/Genderqueer <input type="checkbox"/> Additional/Other Gender <input type="checkbox"/> Declined to Specify	Race & Ethnicity <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African America <input type="checkbox"/> Declined To Specify <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Not Hispanic or Latino	Preferred language <input type="checkbox"/> English <input type="checkbox"/> Spanish/Castilian <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> German <input type="checkbox"/> French <input type="checkbox"/> Declined To Specify <input type="checkbox"/> Other <input type="text"/>
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Primary Insurance <input type="text"/>			
Insured's Name (First Name, Middle Initial, Last Name)			
Insured's Address		Address Line 2	
City	State	Zip	Country
Insured's ID No	Group No	Insured's DOB	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F
Pt Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

Secondary Insurance <input type="text"/>			
Insured's Name (First Name, Middle Initial, Last Name)			
Insured's Address		Address Line 2	
City	State	Zip	Zip
Insured's ID No	Group No	Insured's DOB	Sex
			<input type="checkbox"/> M <input type="checkbox"/> F
Pt Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			

How did you initially find our office? (Specify one)

Please Read:
In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Patient History and Information

Referring Physician

M.D. P.A. N.P. R.N. O.D.

Is Primary Care Physician

First Name	Middle	Last Name	Suffix	Clinic Name
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Clinic Address	City	State	Zip	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Health History

Reason for today's exam

When was your last exam? When was your last health exam?

Past illnesses or injuries

Past surgeries

Current eye drops

Current medications

Reactions/sensitivities medicines

Specific allergies

Current Eye Symptoms

Glare Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign Body Sensation <input type="checkbox"/> Yes <input type="checkbox"/> No	Distorted Vision (Halos) <input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	Infection of Eye or Lid <input type="checkbox"/> Yes <input type="checkbox"/> No	Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Light Sensitivity <input type="checkbox"/> Yes <input type="checkbox"/> No	Itching <input type="checkbox"/> Yes <input type="checkbox"/> No	Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No
Tired Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	Mucous Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning <input type="checkbox"/> Yes <input type="checkbox"/> No	Drooping Eyelid <input type="checkbox"/> Yes <input type="checkbox"/> No	Fluctuating Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Dryness <input type="checkbox"/> Yes <input type="checkbox"/> No	Redness <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Central Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Excess Tearing/Watering <input type="checkbox"/> Yes <input type="checkbox"/> No	Sandy or Gritty Feeling <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Side Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Eyelid Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision Distance <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss Of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Pain or Soreness <input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred Vision Near <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No

Eye History

Amblyopia (Lazy Eye) <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Eye Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	PVD (Vitreous Detachment) <input type="checkbox"/> Yes <input type="checkbox"/> No
Infection of Eye or Lid <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Injuries <input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract <input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma Suspect <input type="checkbox"/> Yes <input type="checkbox"/> No	Keratoconus <input type="checkbox"/> Yes <input type="checkbox"/> No
Color Blindness <input type="checkbox"/> Yes <input type="checkbox"/> No	High Risk Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Corneal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetic Retinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No	Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No	Other <input type="checkbox"/> Yes <input type="checkbox"/> No

General Health Condition

Fever, Weight Loss, Fatigue, etc <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney, Bladder issues <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid, Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
Ears, Nose, Throat issues <input type="checkbox"/> Yes <input type="checkbox"/> No	Muscles, Bones, Joints issues <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood (Cholesterol, Anemia, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular (High BP etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No	Skin (Rash, Itching, etc) <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergic, Immuno <input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory (Asthma) <input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological (Multiple Sclerosis) <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal <input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety or Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical History Questionnaire

Family History

Amblyopia (Lazy Eye) Yes No
Blindness Yes No
Cataract(s) Yes No
Color Blindness Yes No
Eye Tumors Yes No
Glaucoma Yes No
Glaucoma Suspect Yes No

Macular Degeneration Yes No
Retinal Detachment Yes No
Strabismus (Eye Turn) Yes No
Arthritis Yes No
Cancer Yes No
Diabetes Yes No
Heart Disease Yes No

High Blood Pressure Yes No
Kidney Disease Yes No
Lupus Yes No
Stroke Yes No
Thyroid Disease Yes No
Others Yes No

Social History

Do you drink alcohol? No Occasional 1 Per Day 2-3 Per Day 4+ Per Day

Smoking status

Tobacco use cessation intervention, counselling? Yes No

Current occupation Years

Tobacco use cessation pharmacologic therapy? Yes No

Employer

Do you use illegal drugs Yes No

Do you engage in regular exercise? Yes No

Hobbies/Interests

Use nutritional supplements (vitamins etc.)? Yes No

Spectacle Lens History

Do you use a computer? Yes No

How many hours/day? Distance from Computer?

Do you drive? Yes No

Mileage to work each way?

Do you have glare problems? Yes No

Visual difficulty when driving? Yes No

Problems with night vision? Yes No

Do you currently wear glasses? Yes No Since

Type of glasses Full Time Part Time Distance Close

Glasses owned Single Vision Bifocals Trifocals Backup Safety Sports Progressive

Trouble in the past with glasses? Yes No

Do you wear sunglasses? Yes No Are your sun glasses your current prescription? Yes No

Special Eyewear Needs

Computer (special prescriptions, special anti-glare tints or coatings) Safety glasses (gardening, woodworking, welding)

Occupational (mechanics, plumbers, pilots) Sports/Hobbies (racquet sports, motorcycle)

Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

Have you ever tried to wear contact lenses? Yes No

Reason for stopping?

Do you currently wear contact lenses? Yes No

Since

Type and brand of contact lenses

How many days/week?

How many hours/day?

Today's Wearing Time

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being Excellence

	Left	Right
Lens comfort	<input type="text"/>	<input type="text"/>
Distance vision	<input type="text"/>	<input type="text"/>
Near vision	<input type="text"/>	<input type="text"/>

What Solutions do you use?

Cleaner	<input type="text"/>
Disinfectant	<input type="text"/>
Enzyme	<input type="text"/>