CONFIDENTIAL PATIENT INFORMATION

Legal Name _____ Preferred Name_____

Mailing Address _____ City _____ State _____ Zip _____

Primary Phone # _____ Email Address _____

Birthdate _____ Last 4 of Social: _____

Are you: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Name of Significant Other or Parent: _____ Phone # _____

Person to contact in case of emergency _____ Phone # _____

Are you: ❑Employed ❑Retired

How did you hear about us? ❑Family ❑Friend ❑Website ❑Google ❑Dear Doc ❑Other _____

Primary Care Physician:_____ Preferred Pharmacy: _____

Consent for Medication Reconciliation ❑Yes* ❑No (If no, please supply medication list) _____

_____

If you mark Yes, we are able to download your prescriptions directly from your pharmacy.

Reason for today's exam ❑Yearly exam ❑Diabetic eye exam ❑Medical eye problem ❑Other_____

_____

Approximate date of last eye exam _____

Health History on Reverse

CONFIDENTIAL HEALTH HISTORY

Do you or anyone in your immediate family have a history of the following?

	No	Self	Family Relationship		No	Self	Family Relationship
Pre Diabetes	❑	❑	❑_____	High blood pressure	❑	❑	❑_____
Diabetes	❑	❑	❑_____	Macular Degeneration	❑	❑	❑_____
Cataracts	❑	❑	❑_____	Heart condition	❑	❑	❑_____
Glaucoma	❑	❑	❑_____	Retinal Detachment	❑	❑	❑_____
Thyroid	❑	❑	❑_____	Auto Immune Disease*	❑	❑	❑_____

*Please specify _____

Please check whether any of the following conditions apply to you:

No	Yes	No	Yes	No	Yes
❑	❑ Frequent headaches	❑	❑ Allergies to medications	❑	❑ Pregnant
❑	❑ Allergies	❑	❑ Sinus trouble	❑	❑ Given birth in the last 6 months

Have you ever had any of the following conditions involving your eyes?

No	Yes	No	Yes	No	Yes
❑	❑ Severe pain	❑	❑ Sensitivity to light	❑	❑ Eye infection or disease
❑	❑ Eye injury	❑	❑ Floaters or spots	❑	❑ Double vision
❑	❑ Medical treatment	❑	❑ Poor distance vision	❑	❑ Eye strain
❑	❑ Eye Surgery*	❑	❑ Poor near vision	❑	❑ Eyes burn, itch, or water

*What Eye Surgery? _____

Any Additional Info?: _____

Smoking History: ❑Never ❑Former ❑Current

Do you currently wear glasses? ❑ Yes ❑ No

When do you wear your glasses?

❑ All the time	❑ Reading/near work
❑ Work safety	❑ Distance tasks only
❑ Computer work	❑ Other, please explain _____

Have you ever worn contacts? ❑ Yes ❑ No Are you interested in wearing contacts? ❑ Yes ❑ No

What work/hobbies do you participate in that require specific eyewear? ❑Computer ❑Golf ❑Shooting ❑Reading

❑Sports ❑Other_____

X _____ Date _____

SIGNATURE OF PATIENT (or parent if a minor)