PATIENT INFORMATION

Name_____ Home Phone_____ Cell #_____ Date_____
Address _____Work Phone_____ Age:____ Date of Birth_____ M F
_____Who referred you to our office? _____
Employer or Current Grade in School_____ Your e-mail address_____
Major medical/vision insurance co.? _____
Who is financially responsible ? _____Relationship:_____
Address_____ Phone _____
Physician's Name _____

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO RECEIVE CARE IN THIS OFFICE AND ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE.

PATIENT/GUARANTOR SIGNATURE_____**DATE**_____

Current Medications: (We can copy your list)_____
_____
Medical Allergies:_____
Over The Counter Medications_____

YES	NO	
_____	_____	Do you enjoy reading?
		How long can you read comfortably? _____
_____	_____	Do you think that you should be able to read longer?
_____	_____	Do you have difficulty maintaining your attention while reading?
_____	_____	Do you tend to skip words or lines of print while reading?
_____	_____	After reading or doing other close work do you look up and notice that objects are momentarily blurred?
_____	_____	Does the print ever blur when you are reading?
_____	_____	Do your eyes itch, burn, water, pull, ache, or feel dry?
		If so, which symptoms do you experience and when? _____
_____	_____	Do you ever experience double vision?
_____	_____	Does your vision ever blur when looking far away?
_____	_____	Do your eyes or vision make reading or homework more difficult at the end of the day?
_____	_____	Are you aware of any tendency to move your head closer or farther away from what you are doing?
_____	_____	Do you see any halos around lights, floaters, or apparent flashes of light?
		If so, which ? _____ Have they changed recently? _____
_____	_____	Have you ever had any operations or injuries to your eyes?
		If so, please list and date. _____
_____	_____	Does using a computer cause you eyestrain ?
		What are the height and distance of the screen relative to your eyes?
		Height_____ Distance_____
		How much time do you use hand - held electronic media? (iPad, text)_____
		What are your pastimes?_____
_____	_____	Does your vision ever interfere with your pastime activities?
		If so, in what ways? _____
_____	_____	Are you involved in any hazardous occupations, pastimes, or sports?
		If so, which ones?_____
_____	_____	Is driving stressful to you?
_____	_____	Do you experience discomfort while shopping?

OVER

	YES	NO	
Constitution			
	_____	_____	Is there any history in your blood relatives of any eye problems including glaucoma, detached retina, or macular degeneration? If so, what condition and what is their relationship? _____ _____
	_____	_____	Does anyone in your family have a medical condition such as diabetes? If so, what condition and what is their relationship? _____
	_____	_____	Have you had any recent gain or loss of weight?
	_____	_____	Have you had any recent changes in your diet?
	_____	_____	Do you get adequate rest?
	_____	_____	Do you have a sleep disorder?
	_____	_____	Do you use or have you used tobacco?
	_____	_____	Do you drink alcohol?
	_____	_____	Do you use other substances?
ENT	_____	_____	Do you experience sinus congestion or chronic sinusitis?
	_____	_____	Do you have problems with a dry throat or mouth?
Respiratory	_____	_____	Do you have asthma, emphysema, or COPD?
	_____	_____	Do you use any inhalers?
Cardiovascular	_____	_____	Do you have high blood pressure?
	_____	_____	Do you have a history of heart problems or stroke?
Cenitourinary	_____	_____	Do you have a problem with frequent urination?
	_____	_____	Do you have a history of kidney disease?
Integumentary	_____	_____	Do you have a history of skin rashes or skin cancer?
	_____	_____	Do you have a history of rosacea?
Neurological	_____	_____	Do you have a history of migraines?
	_____	_____	Do you have a history of other headaches?
	_____	_____	Do you have problems with your balance?
Endocrine	_____	_____	Do you have diabetes? If so, what is your most recent HbA1c? _____
	_____	_____	Do you have thyroid disease?
Allergic	_____	_____	Do your allergies affect your eyes?
	_____	_____	Have you ever had any allergies to metals like nickel?
Psychiatric	_____	_____	Do you experience depression which is difficult to control?
	_____	_____	Do you experience anxiety which is difficult to control?
	_____	_____	Do you have periods of excessive fatigue?

Contact Lens Patients: Please answer the following questions & have your contact lenses as well as your glasses with you when you come in for your evaluation.

_____	_____	Do you have any difficulty seeing with your contact lenses?
_____	_____	Do you experience any discomfort or dryness while wearing your lenses?
_____	_____	Do you experience any redness or secretions of your eyes?
_____	_____	Do you nap or sleep with your lenses on?
_____	_____	Do you air dry your case?
_____	_____	Do you use any eye drops while wearing your lenses? If so, what? _____
_____	_____	Can you easily switch between your contact lenses and glasses?
		How often do you replace your contact lenses? _____
		What is your typical wearing schedule? _____
		What solutions do you use? _____

Please bring your contact lens solution

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FAMILY EYE CARE
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