PATIENT HISTORY FORM DATE:

NAME: LAST: _____ FIRST: _____ PARENT/GUARDIAN: _____

DOB: _____ AGE: _____ WILL YOU BE USING INSURANCE TODAY? YES OR NO NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

EMAIL: _____ HOBBIES: _____

OCCUPATION: _____ IF PREGNANT, PLEASE STATE NUMBER OF MONTHS: _____

MEDICAL HISTORY:

PLEASE LIST CURRENT MEDICATIONS: _____

PLEASE LIST ANY ALLERGIES (MEDICAL OR ENVIRONMENTAL _____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOU:
IN THE LAST COLUMN, CIRCLE S FOR SELF – AND CIRCLE F FOR FAMILY AND INDICATE HOW LONG YOU HAVE HAD THE CONDITION:

( ) AMBLYOPIA – LAZY EYE
( ) BLURRED VISION – Near
( ) BLURRED VISION _ Far
( ) CATARACTS: YEAR _____
( ) CHALAZION/STYES
( ) COLOR BLINDNESS
( ) DOUBLE VISION
( ) DRYNESS
( ) EXCESS TEARING/WATERING
( ) FLASHES
( ) FLOATERS
( ) FLUCTUATING VISION
( )FOREIGN BODY SENSATION
( ) GLARE/LIGHT SENSITIVITY
( ) HEADACHES/MIGRANES
( ) LAZY EYE ( ) RIGHT ( ) LEFT
( ) LOSS OF VISION
( ) REDNESS
( )RETINAL DETACHMENT
( ) SURGERY (EYE) TYPE AND YEAR: _____

( ) CANCER SELF FAMILY _____
( ) DIABETES SELF FAMILY _____
( ) GLAUCOMA SELF FAMILY _____
( ) HEART DISEASE SELF FAMILY _____
( ) HIGH BLOOD PRES SELF FAMILY _____
( ) HIGHT CHOLEST SELF FAMILY _____
( ) MACULAR DEGEN. SELF FAMILY _____
( ) THYROID DISEASE SELF FAMILY _____

PREVIOUS EXAM INFORMATION

HAVE YOU EVER HAD AN EYE EXAM BEFORE? YES NO -> -> IF YES, HAVE YOU BEEN TO OUR OFFICE BEFORE? YES NO
IF NOT, PLEASE TELL US WHERE YOU HAD YOUR LAST EXAM: _____

REASON FOR YOUR EXAM TODAY (PLEASE CHECK ALL THAT APPLY:

( ) I NEED AN EYE EXAM FOR GLASSES ( ) I NEED AN ANNUAL EYE EXAM FOR CONTACTS (includes glasses prescription
( ) I LOST/BROKE MY GLASSES ( ) I WOULD LIKE TO GET **OPTOMAP** – (*circle one*) YES NO MAYBE
( ) I HAVE AN INFECTION / RED EYES ( ) DILATION IS AN OPTION

ANSWER THE QUESTIONS IN THIS COLUMN BELOW:

HAVE YOU EVER WORE GLASSES BEFORE? YES NO

IF YOU HAVE, DO YOU CURRENTLY WEAR GLASSES? YES NO
IF YES, DID YOU BRING YOUR GLASSES TODAY? YES NO

HOW OLD ARE YOUR GLASSES? _____
TYPE: ( ) SINGLE VISION ( ) BIFOCAL ( ) TRIFOCAL
( ) PROGRESSIVE- (No line) ( ) READERS ( ) OTHER

DO YOU USE THE COMPUTER? YES NO
HOW MANY HOURS PER DAY? _____

ANSWER THE QUESTIONS BELOW: ONLY IF YOU ARE DOING CONTACT EXAM:

HAVE YOU EVER WORE CONTACTS BEFORE? YES NO

IF YOU HAVE, DO YOU CURRENTLY WEAR CONTACTS? YES NO
IF YES, HOW OFTEN DO YOU REPLACE THEM? _____
ARE YOU WEARING YOUR CONTACTS TODAY? YES NO
WHAT BRAND? ( ) AV OASYS ( ) AIR OPTIX AQUA ( ) BIOFINITY
( ) BAUSCH & LOMB ( ) OTHER _____

ARE YOU HAPPY WITH YOUR CURRENT BRAND? YES NO
DO YOU REMEMBER YOUR PRESCRIPTION? YES NO
RIGHT: _____
LEFT: _____

ARE YOU INTERESTED IN COLOR CONTACTS? YES NO

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROVIDE THE MOST BENEFICIAL AND COMPLETE VISUAL EXAMINATION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALLL CHARGES WHETHER OR NOT PAID BY INSURANCE. I UNDERSTAND THAT ALL FEES PAID FOR PROFESSIONAL SERVICES ARE NON-REFUNDABLE AND ARE PAYABLE AT THE TIME OF SERVICE. MY SIGNATURE INDICATES THAT I HAVE BEEN INFORMED OF MY RIGHTS UNDER THE HIPPA PRIVACY POLICIES.

SIGNATURE: _____ DATE: _____