PATIENT INFORMATION AND HISTORY

Date ________ Last Name ________________ First Name _____________ MI ___ Birthdate ________Age ____ M or F
Address ______________________________________ City ______________________ State _______ Zip __________
Home Phone ______________ Work Phone ______________ Cell Phone _____________ Email ___________________
Social Security No. _______________ Employer or School _________________________ Occupation ______________
Spouse's Name _______________________ If Child, Parent's Name _____________________ Birthdate ____________
Emergency Contact ____________________________ Relationship ________________ Phone ____________________
How did you hear about Eyes Optometry and whom may we thank? ____

VISION INSURANCE
Name of Insurance Co. _____________________________ Subscriber's Name _________________________________
Social Security No. __________________________ Birthdate __________ Relationship to Patient __________________

MEDICAL INSURANCE
Name of Insurance Co. _____________________________ Subscriber's Name _________________________________
Social Security No. __________________________ Birthdate __________ Relationship to Patient __________________

Physician's Name _______________________ Date of Last Physical ___________ Date of Last Eye Exam ___________

Do you wear glasses? ❑Yes ❑ No
Do you wear prescription sunglasses? ❑Yes ❑ No
Do you wear contact lenses? ❑Yes ❑ No
If No, are you interested in wearing contact lenses either full time, part time, or occasional use? ❑Yes ❑ No
Are you interested in laser vision correction? ❑Yes ❑ No
Are in interested in non-surgical vision correction? ❑Yes ❑ No
Do you use a computer at home or at work? ❑Yes ____ hours/day ❑ No
Do you do a lot of reading or writing? ❑Yes ❑ No
Do you experience any eye strain, headaches, or blurred vision while using a computer or reading? ❑Yes ❑ No
Have you ever had an eye injury or infection? ❑Yes ❑ No
If Yes, please describe: ____

Do you experience any of the following conditions?

❑ Blurred Vision	❑ Double Vision	❑ Sandy/Gritty Eyes	❑ Watery Eyes	❑ Eye Pain
❑ Dry Eyes	❑ Headaches	❑ Eye Strain	❑ Burning Eyes	❑ Loss of Vision
❑ Itchy Eyes	❑ Red Eyes	❑ Flashing Lights	❑ Floating Spots	❑ Fluctuating Vision

Other conditions not listed above: ____

Have you or your blood relatives had any of the following conditions?

	YOURSELF	FAMILY		YOURSELF	FAMILY
Cataract	❑Yes ❑ No	❑Yes ❑ No	Diabetes	❑Yes ❑ No	❑Yes ❑ No
Glaucoma	❑Yes ❑ No	❑Yes ❑ No	Arthritis	❑Yes ❑ No	❑Yes ❑ No
Crossed Eyes	❑Yes ❑ No	❑Yes ❑ No	Thyroid disease	❑Yes ❑ No	❑Yes ❑ No
Lazy Eyes	❑Yes ❑ No	❑Yes ❑ No	Stroke	❑Yes ❑ No	❑Yes ❑ No
Eye Surgery	❑Yes ❑ No	❑Yes ❑ No	Lupus	❑Yes ❑ No	❑Yes ❑ No
Blindness	❑Yes ❑ No	❑Yes ❑ No	High Blood Pressure	❑Yes ❑ No	❑Yes ❑ No
Retinal Detachment	❑Yes ❑ No	❑Yes ❑ No	Heart Disease	❑Yes ❑ No	❑Yes ❑ No
Macular Degeneration	❑Yes ❑ No	❑Yes ❑ No	Cancer	❑Yes ❑ No	❑Yes ❑ No

Other condition not listed above: ____

Please list any prescription or non-prescription medication that you are currently taking, including eyedrops:

____

Please list any allergies you have to medications, foods, or the environment:

____

Do you use tobacco? ❑Yes ❑ No ______ packs/day Do you drink alcohol? ❑Yes ❑ No ______ drinks/day
Are you pregnant? ❑Yes ❑ No Please list other information doctor should be aware of: _________________________

Patient's Signature: Date:

Doctor's Signature: Date: