Today's Date: ___/___/____	**Reason for Visit:**
Mr. Mrs. Ms. Jr. Sr. II III	**Last Name:** **First Name:** **MI:** **M F**
Patient Date of Birth: _____/_____/_____	**Street Address: _____** **City: _____ State: _____ Zip Code: _____**

Preferred Phone: (____)_____ home/cell/work	**Receive Text Messages? Y N**
Alternate Phone: (____)_____home/cell/work	**Email address: _____**

Marital Status: S M D W LS P	**Height:** ft in	**Weight: Lbs.**	**Primary Language:**

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Other	**Ethnicity:** Not Hispanic/Latino Hispanic/Latino Unknown Decline to Specify

Occupation:	**Employer:**
Status: Full-time Part-time Unemployed Retired	**SSN#: _____-_____-_____**
Emergency Contact:	**Phone: (_____)_____**

Insurance Information:

Responsible Party:	**DOB: / /**	Self Spouse Dep. Child
Medical Insurance:	**ID#:**	Self Spouse Dep. Child
Primary Care Physician:	**Last Visit: / /**	**Last Physical Exam: / /**
Primary Vision Insurance:	**ID#:**	Self Spouse Dep. Child
Secondary Insurance Plan:	**ID #:**	Self Spouse Dep. Child

Today's Visit:

New Patient? Yes No	**Date of last Eye Exam: / /**	**Were your eyes dilated?** Yes No
Name of Optometrist:		**Age of current glasses?** mo's yrs

Are you currently wearing:			**Trouble with:**			**Are you interested in:**		
Glasses	Yes	No	**Night Driving**	Yes	No	**Ortho K/CRT**	Yes	No
Contact Lenses	Yes	No	**Reading**	Yes	No	**Color/Cosmetic Contacts**	Yes	No
Sunglasses	Yes	No	**Glare/Bright light**	Yes	No	**LASIK?**	Yes	No
Sports Goggles	Yes	No	**Eye Fatigue/Strain**	Yes	No	**Computer Glasses?**	Yes	No

Referred by: Family Friend Insurance Doctor Google Yelp Facebook Walk-by Other
Name of Family/Friend so we may Thank them:

Personal and Family Health History

Do you or does anyone in your family have the following disease or conditions? Indicate family relationship below:

	SELF	/ FAMILY		SELF	/ FAMILY
Allergic/Immunological	Y N		Hepatitis	Y N	
Amblyopia	Y N		High Blood Pressure	Y N	
Arthritis/Joint Disease	Y N		High Cholesterol	Y N	
Blindness	Y N		HIV/AIDS	Y N	
Blood/Lymph	Y N		Integumentary/Skin	Y N	
Blurred/Double Vision	Y N		Last Menstrual/Pregnancy	Y N	
Cancer	Y N		Lupus	Y N	
Cardiovascular/Stroke	Y N		Macular Degeneration	Y N	
Cataracts	Y N		Mental/Psychological	Y N	
Contact Lenses (type)	Y N		MS	Y N	
Diabetes (I, II, Borderline Gest.)	Y N		Muscles/Bones	Y N	
Dry Eyes	Y N		Neurological	Y N	
Ears, Nose, Throat	Y N		Operations/Surgeries (LIST)	Y N	
Endocrine Glands/Thyroid	Y N		Refractive	Y N	
Eye Injury/Eye Surgery	Y N		Respiratory/ Asthma	Y N	
Flashes/Floaters	Y N		Retinal Detachment	Y N	
Gastrointestinal/Chron's	Y N		STD's	Y N	
Glasses	Y N		Strabismus	Y N	
Glaucoma	Y N		Urinary/Bladder	Y N	

Circle one: Current/Former/Never Smoker

Circle One: Social/Occasional/Daily/Never Alcohol

Do you use any drugs/substances/over the counter medications? Y N _____

Allergies to Medications? _____

Reaction? _____

Computer _____HRS/Day

Hobbies? _____

Please list all current medications, vitamins, and supplements you are currently taking.

Medication Name	1.	2.	3.	4.	5.	6.
When prescribed						
For what condition						