Welcome to Our Clinic

Today's Date:

PATIENT INFORMATION FORM

Last Name	First Name	Birthday	Sex ☐ Male ☐ Female
Address	City	State	Zip
Email Address	Home Phone	Work Phone	

Method of Payment ☐ Cash ☐ Credit Card ☐ Insurance

Occupation	Insurance Company	

MEDICAL HISTORY

Do you have problems with any of the following? ***(Please circle Y for yes and N for no)***

Gastrointestinal	Y/N	Genitourinary	Y/N	Blood /Lymph	Y/N	Med allergy	Y/N
Ears/Nose/ Throat	Y/N	Musculoskeletal	Y/N	Allergic / Immunologic	Y/N	Headaches	Y/N
Cardiovascular	Y/N	Integumentary (skin)	Y/N	Diabetes	Y/N		Y/N
Respiratory	Y/N	Mental	Y/N	High Blood Pressure	Y/N		
Nervous	Y/N	Endocrine(glands) including Thyroid	Y/N				

Have you had any operation? Y/N Kind? When?

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N Other substances? Y/N

Name of family doctor:_____ Date of last visit? _____

Date of last tetanus shot?

List any other medical condition you are being treated for:	List medications you are taking(including)birth control)

Is there a family history of any of the following? ***(Please circle Y for yes and N for no and list relation for Y answers)***

High Blood Pressure	Y/N	Retinal Detachment	Y/N
Diabetes	Y/N	Cataracts	Y/N
Heart Problems	Y/N	Glaucoma	Y/N
Macular Degeneration	Y/N	Other Eye Conditions	Y/N

EYECARE HISTORY

Headaches	Y/N	Itching	Y/N	Glaucoma	Y/N	Other eye condition If yes, explain.	Y/N
Floaters	Y/N	Burning	Y/N	Cataracts	Y/N		
Flashes	Y/N	Tearing	Y/N	Blurred Vision- Far	Y/N		
Red Eyes	Y/N	Seeing Double	Y/N	Blurred Vision- Near	Y/N		
Pain in Eyes	Y/N	Crossed Eyes	Y/N	Haloes around Light	Y/N	Any eye surgery?	Y/N
Eye Infections	Y/N	Amblyopia (Lazy eye)	Y/N	Eyelid Twitching	Y/N		
Dry Eyes	Y/N	Had Vision Therapy	Y/N	Light Bother You	Y/N		

Date of Last Eye Exam:	By whom?	Are you on a computer? Y/N If So, how many hours per day?

Do you currently wear glasses? Y/N	When and where were they purchased?					
Have you worn contact lenses? Y/N	☐ Rigid	☐ Soft	☐ Disposable	☐ Daily wear	☐ Extended wear	☐ Tinted
Do you want contact lenses? Y/N	☐ Rigid	☐ Soft	☐ Disposable	☐ Daily wear	☐ Extended wear	☐Tinted

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Referral	☐ Mail out	☐ Recall card	☐ Walk-In	☐ Insurance	☐ Internet	☐ Other (List Below)	

Whom may we thank for tellling you about our practice? Address		
City	State	Zip
Form: (0801) Patient Information Form	Doctor's Initials	