

# Welcome To Our Office

Today's Date \_\_\_\_\_ Patients SS# \_\_\_\_\_ E-mail address \_\_\_\_\_  
Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M or F  
Spouses (or Parent's) Name \_\_\_\_\_ Patients Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
Employer (or School) \_\_\_\_\_ Work Phone \_\_\_\_\_  
Occupation (or School Grade) \_\_\_\_\_ Sports/Hobbies \_\_\_\_\_  
Medical Insurance \_\_\_\_\_ Primary Care Physician \_\_\_\_\_ Last Physical \_\_\_\_\_  
Vision Insurance \_\_\_\_\_ How will you settle your account today? Cash • Check • Credit Card • Care Credit  
Referred By (please circle): family, friend, yellow pages, internet, ins. co., physician, our location/website, Raytheon Mag., Explorer News  
Name of person who referred you? \_\_\_\_\_

I have received or was offered a notice of privacy practices. Signature \_\_\_\_\_

I understand that I am responsible for services not covered by insurance. Signature \_\_\_\_\_

• • • • • • **• Vision History •** • • • • • • • •

What is the primary purpose of this visit? \_\_\_\_\_  
Date of last examination \_\_\_\_\_ By Dr. \_\_\_\_\_ Did you receive glasses and/or contact lenses? Yes No N/A  
Do you now, or have you ever worn glasses?..... Yes No  
Do you have an adequate emergency (back-up) pair of glasses?..... Yes No N/A  
Are you planning on ordering new glasses today?..... Yes No  
Can you read as long as you would like to comfortably?..... Yes No N/A  
If you wear line bifocals, does the line bother you?..... Yes No N/A  
Do you now or have you ever worn contact lenses? Yes No If yes, what type \_\_\_\_\_ Lens replacement schedule \_\_\_\_\_  
Are you interested in wearing contact lenses?..... Yes No N/A  
Are you interested in wearing contact lenses at night while you sleep?..... Yes No N/A  
Have you ever had an eye injury, disease, surgery or infection? (circle those that apply)..... Yes No  
Do your eyes tire frequently?..... Yes No  
Do you often experience blurry vision?..... Yes No  
Do you have chronic red, irritated, dry, itchy, burning or watery eyes? (circle those that apply)..... Yes No  
Do you have headaches more than once per week?..... Yes No  
Do you look at a computer screen for 3 or more hours per day? (Work and home combined)?..... Yes No N/A  
Do your current glasses work to your satisfaction when looking at the computer screen?..... Yes No N/A  
Do you have problems with glare or reflections when driving at night?..... Yes No N/A  
Does sunlight bother you?..... Yes No Do you currently wear sunglasses?..... Yes No  
Have you had refractive surgery?..... Yes No Are you interested in laser vision correction?..... Yes No N/A  
Are you interested in a gentle non-surgical procedure to correct your vision while you sleep that eliminates the need to wear glasses or contacts during the day?..... Yes No N/A

• • • • • • **• Medical History •** • • • • • • • •

Do you or anyone in your household smoke? Yes No Are you pregnant or nursing? Yes No N/A  
Do you have any of the following? (circle all those that apply)  
ADHD • Allergies • Arthritis • Asthma • Cancer • Cataracts • Color Deficiency • Crossed Eyes • Depression  
Diabetes • Double Vision • Drooping Eyelid • Eye Tumor • Flashes • Floaters • Glaucoma • Halos • Heart Disease  
Hepatitis • High Blood Pressure • High Cholesterol • HIV • Hormonal Dysfunction • Kidney Disorder • Lazy Eye • Loss  
of Vision • Lupus • Macula Degeneration • Migraines • Multiple Sclerosis • Parkinson's • Retinal Detachment/Disease  
Sinus Problem • Skin Disorder • Stroke • Thyroid Disorder • Tuberculosis • Any Others? \_\_\_\_\_

Does anyone in your family have any of the above conditions? (list those that apply) \_\_\_\_\_

List any prescriptions or over-the-counter medications you are taking on a daily basis. (Antihistamine, aspirin, birth control, eye drops, hormones, steroids, others) \_\_\_\_\_

Do you have known allergies to medications? Yes No If yes, explain: \_\_\_\_\_

Reviewed by: Dr. \_\_\_\_\_ Date: \_\_\_\_\_