

Patient's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: (Home) _____ (Cell) _____

Male: _____ Female: _____ Marital Status: _____

Date of Birth: _____ SS #: _____

Spouse: _____

If Parent, list the names and ages of children living with you: _____

If Child, Name of Parent or Guardian and Work Phone: _____

Place of Employment: _____

Business Phone: _____ Ext. _____

Occupation: _____

If Student:

School Name: _____ Grade: _____

Person Responsible for Payment: _____

Address (If Different): _____

City: _____ State: _____ ZIP: _____

Date of Last Eye Exam: _____

Do You Wear Glasses? _____ Contacts? _____

For: _____ Near _____ Distance Only _____ Work Only
_____ As Needed _____ Full Time

Whom may we thank for referring you to our office?

Name: _____

List Names of All Insurance and I.D. Numbers:

Primary: _____

Secondary: _____

Third: _____

Subscriber's Name: _____

Have you recently noticed any of the following?

_____ Blur at distance	_____ Pain in or around eyes
_____ Blur at near	_____ Headaches
_____ Eyestrain	_____ Spots floating
_____ Double vision	_____ Bright lights bother eyes
_____ Flashes of light	
_____ Other Symptoms (list)	_____

Have you or anyone in your family (now or in the past) ever had:

Self Family	Self Family
_____ Glaucoma	_____ Strabismus (crossed-eyes)
_____ Eye Surgery	_____ Eye or Head Injuries
_____ Blindness	_____ Myopic (nearsightedness)
_____ Cataracts	_____ Hyperopic (farsightedness)
_____ Allergies	_____ High Blood Pressure
_____ Heart Disease	_____ Sinus Problems
_____ Diabetes	_____ Thyroid Disease
_____ Other (List)	_____

List Current Medications: _____

Date of your last general health exam: _____

Activities: (List)

Sports: _____ Computer Operator: _____

Hobbies: _____ Musical Instruments: _____

Other: _____

Would you like to ask about contact lenses or a particular eyeglass prescription? _____

Signature: _____ Date: _____