

**Welcome to Our Office**

Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (Home) (\_\_\_\_) \_\_\_\_\_ (Work) (\_\_\_\_) \_\_\_\_\_ Best time to be contacted \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Parent's Name (if minor) \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
If Student, Grade \_\_\_\_\_ School \_\_\_\_\_ Occupation \_\_\_\_\_  
Responsible Party for Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Sex:  Male  Female Payment Preference:  Cash  Check  Visa/MC/Discover Do you have insurance?  Yes  No  
If you have insurance, please list insurance provider \_\_\_\_\_ I.D. number \_\_\_\_\_  
Policy holder's name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_  
Who may we contact in case of an emergency? \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Eye History/Ocular Review of Systems**

Approximate date of last eye examination \_\_\_\_\_ By Doctor \_\_\_\_\_  
Do you wear glasses?  Yes  No If yes, when were they prescribed? \_\_\_\_\_  
Do you wear contact lenses?  Yes  No If yes, when were they prescribed? \_\_\_\_\_  
Would you like to wear contact lenses?  Yes  No Have you ever worn contact lenses?  Yes  No  
Are you interested in refractive surgery (LASIK)?  Yes  No Have you ever received eye exercises?  Yes  No  
Do you wear sunglasses?  Yes  No Do you feel your vision problems occur at  Distance  Near  Neither  
Do you currently have or have you ever had any of the following problems?  

<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Excess Tearing/Watering	<input type="checkbox"/> Eye Pain
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Eye Infections
<input type="checkbox"/> Distorted Vision/Halos	<input type="checkbox"/> Redness	<input type="checkbox"/> Eye Injuries
<input type="checkbox"/> Loss of Side Vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Eye Surgery
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Retinal Detachment/Disease
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Foreign Body Sensation	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Floaters in Vision	<input type="checkbox"/> Sandy or Gritty Feeling	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Flashes of Light in Vision	<input type="checkbox"/> Eye Strain/Tired Eyes	<input type="checkbox"/> Macular Degeneration
<input type="checkbox"/> Twitching Eye Lids	<input type="checkbox"/> Light Sensitivity/Glare	<input type="checkbox"/> Crossed Eyes/Lazy Eye
	<input type="checkbox"/> Decreased Night Vision	

**Medical History**

Are you presently taking any medications (including over the counter medications, hormones, or birth control)?  Yes  No  
If yes, please list \_\_\_\_\_  
Do you have any allergies to medications?  Yes  No If yes, please list \_\_\_\_\_  
List all major injuries, surgeries, and/or hospitalizations you have had \_\_\_\_\_  
Are you pregnant and or nursing?  Yes  No  
Approximate date of last general health exam \_\_\_\_\_ Family Physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**Family History**

Please note any family history (parents, grandparents, siblings, children, aunts, uncles) for the following conditions:

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>?</b>	<b>Relationship to You</b>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*Please turn this sheet over and complete the other side.*

**Social History**

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss this information with the doctor.

Employer \_\_\_\_\_ Address \_\_\_\_\_

Are you:  Married  Single  Divorced  Widowed Do you drive?  Yes  No Do you use a computer?  Yes  No

What are some of your hobbies? \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with any of the following?  Gonorrhea  Hepatitis  HIV  Syphilis

**Review of Systems**

Do you currently or have you ever had any problems in the following areas?

<b>System</b>	<b>Yes</b>	<b>No</b>	<b>?</b>		<b>Yes</b>	<b>No</b>	<b>?</b>
<b>Constitutional</b> (fever, weight loss, gain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/Cardiovascular</b>			
<b>Integumentary</b> (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>				High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ears, Nose, Mouth, Throat</b>				High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies, Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b> (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>			
<b>Cancer</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Allergic/Immunologic</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b> (thyroid/other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Authorization**

*I certify that the above questions have been accurately answered to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and the records of any treatment given to me or my dependants to third party payers and/or health practitioners. If applicable, I authorize my insurance company to pay directly to the doctor insurance benefits on my behalf. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be ultimately responsible for payment of services rendered to me or my dependants.*

\_\_\_\_\_  
Signature of Patient (or parent if minor)

\_\_\_\_\_  
Date

**Additions** (for doctor use)

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\_\_\_\_\_  
Doctors Signature

\_\_\_\_\_  
Date