

Patient History

Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

Patient's Name ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.						Patient ID:	
Last Name	Middle	First Name	Suffix	Preferred	DOB (mm/dd/yy)	SSN	

Patient's Address		Address Line 2		Primary Phone ☐ Home ☐ Mobile	Day/Work Phone
City	State	Zip	Country	Emergency Contact	Emergency Phone
Email			Person responsible for this A/C		

Height ft in cm/m	Authorized to discuss health info Name
☐ ft in ☐ cm ☐ m	
Weight lbs kg	Relationship to patient

Sex ☐ Male ☐ Female	Patient Status ☐ Single ☐ Married ☐ Other	Student ☐ Full Time ☐ Part Time	Employed ☐
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Sexual Orientation ☐ Straight/Heterosexual ☐ Gay/Lesbian/Homosex ☐ Bisexual ☐ Other ☐ Unknown ☐ Declined to Specify	Gender Identity ☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Neither/Genderqueer ☐ Additional/Other Gender ☐ Declined to Specify	Race & Ethnicity ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African America ☐ Declined To Specify ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race ☐ Not Hispanic or Latino	Preferred language ☐ English ☐ Spanish/Castilian ☐ Chinese ☐ Japanese ☐ Vietnamese ☐ Korean ☐ German ☐ French ☐ Declined To Specify ☐ Other
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Primary Insurance			
Insured's Name (First Name, Middle Initial, Last Name)			
Insured's Address		Address Line 2	
City	State	Zip	Country
Insured's ID No	Group No	Insured's DOB	Sex
			☐ M ☐ F
Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other			

Secondary Insurance			
Insured's Name (First Name, Middle Initial, Last Name)			
Insured's Address		Address Line 2	
City	State	Zip	Zip
Insured's ID No	Group No	Insured's DOB	Sex
			☐ M ☐ F
Pt Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other			

How did you initially find our office? (Specify one)

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

Signature _____ Date _____

Patient History and Information

Referring Physician

☐ M.D. ☐ P.A. ☐ N.P. ☐ R.N. ☐ O.D.

☐ Is Primary Care Physician

First Name

Middle

Last Name

Suffix

Clinic Name

Clinic Address

City

State

Zip

Phone

Health History

Reason for today's exam

When was your last exam?

When was your last health exam?

Past illnesses or injuries

Past surgeries

Current eye drops

Current medications

Reactions/sensitivities medicines

Specific allergies

Current Eye Symptoms

Glare Sensitivity ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Light Sensitivity ☐ Yes ☐ No

Tired Eyes ☐ Yes ☐ No

Burning ☐ Yes ☐ No

Dryness ☐ Yes ☐ No

Excess Tearing/Watering ☐ Yes ☐ No

Eyelid Swelling ☐ Yes ☐ No

Eye Pain or Soreness ☐ Yes ☐ No

Foreign Body Sensation ☐ Yes ☐ No

Infection of Eye or Lid ☐ Yes ☐ No

Itching ☐ Yes ☐ No

Mucous Discharge ☐ Yes ☐ No

Drooping Eyelid ☐ Yes ☐ No

Redness ☐ Yes ☐ No

Sandy or Gritty Feeling ☐ Yes ☐ No

Blurred Vision Distance ☐ Yes ☐ No

Blurred Vision Near ☐ Yes ☐ No

Distorted Vision (Halos) ☐ Yes ☐ No

Double Vision ☐ Yes ☐ No

Flashes ☐ Yes ☐ No

Floaters or Spots ☐ Yes ☐ No

Fluctuating Vision ☐ Yes ☐ No

Loss of Central Vision ☐ Yes ☐ No

Loss of Side Vision ☐ Yes ☐ No

Loss Of Vision ☐ Yes ☐ No

Other ☐ Yes ☐ No

Eye History

Amblyopia (Lazy Eye) ☐ Yes ☐ No

Infection of Eye or Lid ☐ Yes ☐ No

Blindness ☐ Yes ☐ No

Cataract ☐ Yes ☐ No

Color Blindness ☐ Yes ☐ No

Diabetic Retinopathy ☐ Yes ☐ No

Dry Eye Syndrome ☐ Yes ☐ No

Eye Injuries ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No

Glaucoma Suspect ☐ Yes ☐ No

High Risk Medication ☐ Yes ☐ No

Macular Degeneration ☐ Yes ☐ No

PVD (Vitreous Detachment) ☐ Yes ☐ No

Retinal Detachment ☐ Yes ☐ No

Crossed Eyes ☐ Yes ☐ No

Keratoconus ☐ Yes ☐ No

Corneal Disease ☐ Yes ☐ No

Other ☐ Yes ☐ No

General Health Condition

Fever, Weight Loss, Fatigue, etc ☐ Yes ☐ No

Ears, Nose, Throat issues ☐ Yes ☐ No

Cardiovascular (High BP etc.) ☐ Yes ☐ No

Respiratory (Asthma) ☐ Yes ☐ No

Gastrointestinal ☐ Yes ☐ No

Kidney, Bladder issues ☐ Yes ☐ No

Muscles, Bones, Joints issues ☐ Yes ☐ No

Skin (Rash, Itching, etc) ☐ Yes ☐ No

Neurological (Multiple Sclerosis) ☐ Yes ☐ No

Anxiety or Depression ☐ Yes ☐ No

Thyroid, Diabetes ☐ Yes ☐ No

Blood (Cholesterol, Anemia, etc) ☐ Yes ☐ No

Allergic, Immuno ☐ Yes ☐ No

Pregnant ☐ Yes ☐ No

Nursing ☐ Yes ☐ No

Medical History Questionnaire

Family History

Amblyopia (Lazy Eye) ☐ Yes ☐ No
Blindness ☐ Yes ☐ No
Cataract(s) ☐ Yes ☐ No
Color Blindness ☐ Yes ☐ No
Eye Tumors ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Glaucoma Suspect ☐ Yes ☐ No

Macular Degeneration ☐ Yes ☐ No
Retinal Detachment ☐ Yes ☐ No
Strabismus (Eye Turn) ☐ Yes ☐ No
Arthritis ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Lupus ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Thyroid Disease ☐ Yes ☐ No
Others ☐ Yes ☐ No

Social History

Do you drink alcohol? ☐ No ☐ Occasional ☐ 1 Per Day ☐ 2-3 Per Day ☐ 4+ Per Day

Smoking status

Tobacco use cessation intervention, counselling? ☐ Yes ☐ No

Current occupation Years

Tobacco use cessation pharmacologic therapy? ☐ Yes ☐ No

Employer

Do you use illegal drugs ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Hobbies/Interests

Use nutritional supplements (vitamins etc.)? ☐ Yes ☐ No

Spectacle Lens History

Do you use a computer? ☐ Yes ☐ No

How many hours/day?

Distance from Computer?

Do you drive? ☐ Yes ☐ No

Mileage to work each way?

Do you have glare problems? ☐ Yes ☐ No

Visual difficulty when driving? ☐ Yes ☐ No

Problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No

Since

Type of glasses ☐ Full Time

☐ Part Time

☐ Distance

☐ Close

Glasses owned ☐ Single Vision

☐ Bifocals

☐ Trifocals

☐ Backup

☐ Safety

☐ Sports

☐ Progressive

Trouble in the past with glasses? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No

Are your sun glasses your current prescription? ☐ Yes ☐ No

Special Eyewear Needs

☐ Computer (special prescriptions, special anti-glare tints or coatings)

☐ Safety glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots)

☐ Sports/Hobbies (racquet sports, motorcycle)

Contact Lens History

If not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Reason for stopping?

Do you currently wear contact lenses? ☐ Yes ☐ No

Since

Type and brand of contact lenses

How many days/week?

How many hours/day?

Today's Wearing Time

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being Excellence

	Left	Right
Lens comfort		
Distance vision		
Near vision		

What Solutions do you use?

Cleaner	
Disinfectant	
Enzyme	