



Welcome To Our Office!

Patient Information:

Last name _____ First name _____ MI _____

Mailing Address _____ City _____ State _____ Zip _____

Birthdate _____ Sex: M F SSN _____ Marital Status _____

Cell Phone _____ Texting OK (Non-Marketing)? Yes No Home Phone _____

Work Phone _____ Email Address _____

Occupation _____ Employer _____

Communication Preference: Text to Cell Phone Call to Cell Phone Email Home Phone Work Phone Postal Mail

REVIEW OF SYSTEMS: Do you have health problems with any of these systems? Please check all that apply.

- | | | | |
|--------------------------------------------------------|---------------------------------------------------|------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Immunologic | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Cardiovascular (Heart) | <input type="checkbox"/> Ear, Nose, Mouth, Throat | <input type="checkbox"/> Skin | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Endocrine (Diabetes, Thyroid) | <input type="checkbox"/> Blood/Lymphatic | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Respiratory |

Please explain: _____

MEDICAL HISTORY: Name of Primary Physician _____

Current Medications _____

Medication Allergies _____

Current Medical Conditions _____

Any major surgeries? Please explain _____

Do you use: Tobacco Alcohol Recreational Drugs

Race*: White African American Hispanic Native American Asian Other (*Response Optional)

Ethnicity*: Hispanic Non-Hispanic Pacific Islander Preferred Language*: _____

FAMILY MEDICAL HISTORY: Has anyone in your family had the following conditions? If so, please indicate who.

- | | | |
|-------------------------------------------------|-----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Keratoconus _____ |
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Colorblindness _____ |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Lazy/Turned Eye _____ |
| <input type="checkbox"/> Heart Disease _____ | Other Condition: _____ | |

OCULAR HISTORY: Date of Last Eye Exam _____ By Dr. _____

Have you had any eye surgeries? Yes No Type and Year: _____

Have you had any eye injuries? Yes No Type and Year: _____

- Do you have:
- | | | | | |
|-----------------------------------------------|----------------------------------------|---------------------------------------------|-------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Near Vision Blur | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Watery Eyes |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Distance Blur | <input type="checkbox"/> Floaters | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Strabismus | <input type="checkbox"/> Middle Vision Blur | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Colorblindness | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Headaches | <input type="checkbox"/> Halos/Glare | <input type="checkbox"/> Red Eyes |

Do you currently wear glasses? Yes No Do you currently wear contact lenses? Yes No What kind? _____

What is the reason for today's visit? _____

Are you having any eye problems? _____

Signature _____ Date _____