Welcome to Our Office!

Patient Name: _____Date of Birth:_____

Address:_____City:_____ Zip:_____

Cell#:_____ Home#:_____

Business#:_____ Patient SSN (Last 4 Digits):_____

Email address: _____

Employer + Occupation:_____

If Minor: Parent/Guardian Name:_____

Referred By:_____ Primary Care Physician:_____

Address of PCP:_____ Phone of PCP:_____

Last eye exam:_____ Today's Date: _____

Preferred Pharmacy:_____

Do you wear contact lenses? YES NO

If no, would you be interested in wearing contacts? YES NO

Have you ever had an eye injury, surgery or disease? Yes NO _____

Are you experiencing any eye strain at distance or near? YES NO

Do you have trouble reading street signs or small print? YES NO _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE PAST YEAR:

___blurred vision
___allergies
___poor vision
___eye pain
___asthma
___glaucoma
___diabetes
___cyst or stye
___cataracts
___loss of vision
___high blood pressure
___dry eye
___scalp tenderness
___high cholesterol
___headache
___hay fever
___tearing
___redness
___amaurosis fugax
___fever
___chills
___cough
___dry mouth
___rapid heart beat
___congestion
___shortness of breath
___joint pains
___stiffness
___arthritis
___rash
___seizure
___stroke
___paralysis
___anxiety
___depression
___thyroid abnormalities
___bleeding
___anemia
___emphysema

Are you pregnant or planning to become pregnant? _____

Are you currently taking blood pressure medication? _____

Are you currently taking blood thinner medication? _____

Are you currently taking Flomax? _____

Are you allergic to any medications? _____

Please list all medications (including birth control): _____

_____

_____

*Our office abides by all HIPAA standards. Please feel free to request a copy of our policy.