Welcome to our practice. Please fill out this form completely. All questions are important to your eye care.

First name _____ MI ____ Last name _____ Date of Birth ____/_____/____

Address _____

City _____ State _____ Zip code _____

Cell phone ( ) _____ Home phone ( ) _____Other phone ( ) _____

E-mail address: _____

What is your preferred method of contacting you? Home phone ☐ Cell phone ☐ E-mail ☐

Can our office text and/or e-mail you appt reminders and other information regarding your eye care? Yes ☐ No ☐

Sex: Male ☐ Female: ☐ Occupation _____

Employer / School name if student _____

Marital Status: Never married ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated ☐ Annulled ☐

Primary Care Physician: Name: _____ City: _____ Phone: _____

Do you have Vision Insurance? Yes ☐ No ☐ **Do you have Medical Insurance?** Yes ☐ No ☐

Vision insurance name _____ I.D. #_____ Policy group #_____

Primary Medical Insurance _____ I.D. # _____Policy group # _____

Secondary Medical Insurance _____ I.D. # _____ Policy group # _____

Patient Ocular (eye) History:	**Yes**	**No**
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Cataract	☐	☐
Amblyopia/Strabismus	☐	☐
Blindness	☐	☐
Crossed Eyes	☐	☐
Lazy Eye	☐	☐
Color Blindness	☐	☐
Double Vision	☐	☐
Serious Eye Infection	☐	☐
Flashes/Floaters	☐	☐

Patient Medical History:	Yes	No
Diabetes	☐	☐
Hypertension (high blood pressure)	☐	☐
High Cholesterol	☐	☐
Heart disease	☐	☐
Thyroid condition or disease	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Headaches/Migraines	☐	☐

Other eye conditions: _____

Past Eye Surgeries: _____

Past Eye Injuries: _____

Other medical conditions: _____

Height _____Weight_____

Social History: Race_____ Alcohol use: None ☐ Social ☐ Heavy ☐

Smoking Status: Never ☐ Former smoker ☐ Light (less than 10 cigs/day) ☐ Heavy (more than 10 cigs/day) ☐

Do you use illegal drugs? Yes ☐ No ☐

Welcome to our practice. Please fill out this form completely. All questions are important to your eye care.

Family Ocular History:	None	Mother	Father	Sibling	PGM	PGF	MGM	MGF
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐	☐	☐
Amblyopia/Strabismus	☐	☐	☐	☐	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	☐	☐	☐	☐

Other conditions: _____

Family Medical History:	None	Mother	Father	Sibling	PGM	PGF	MGM	MGF
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐
Cardio Vascular Disease	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐

Patient Medications: (list all Rx medications and non Rx medications or write NONE if you don't take medications)

_____

_____

_____

Patient Medical Allergies: _____

The following are the fourteen (14) individual body systems recognized by insurance guidelines. Please complete your review of systems by writing any problems you currently have regarding each system.

Eyes _____

Allergic/Immunologic (MS, Lupus, RA_____

Musculoskeletal (bones, joints, muscles) _____

Cardiovascular _____

Constitutional (current: ex: fever, weight loss) _____

Ear, nose, mouth, throat _____

Endocrine (ex: diabetes, thyroid) _____

Gastrointestinal _____

Genitourinary _____

Integumentary (skin and/or breast) _____

Lymphatic/Hematologic _____

Nervous system _____

Psychiatric (ex: depression, anxiety, bipolar) _____

Respiratory (ex: asthma, COPD, emphysema) _____