WELCOME TO OUR OFFICE. The following information allows us to provide you with the best care possible.

Name: Last________________________________
First________________________ MI________
Address:____________________________________
City:______________________ Zip Code:________
Social Security Number:______-____-__________
Date of Birth:_________________Age__________
Phone:(H)_________________(W)_____________
E-Mail____
Emergency Contact:__________________________
And Phone:______________________________

Today's Date:______________________________
Occupation (or grade)_______________________
Employer (or school)_______________________
Family members living at home: (please list names and ages)__________________________________
____

How will you settle your account today? (circle)
Cash Check Credit Card

PERSONAL MEDICAL HISTORY

Allergies	No Yes	Arthritis	No Yes
Asthma	No Yes	Cancer	No Yes
Skin Disorder	No Yes	Diabetes	No Yes
Eye Disease	No Yes	Heart Disease	No Yes
Eye Injury	No Yes	Hypertension	No Yes
Eye Surgery	No Yes	Lazy Eye	No Yes
Cataracts	No Yes	Glaucoma	No Yes
Headaches	No Yes	Dry Eyes	No Yes

Other:_____________________________________

Date of last eye exam? ________________________
Dilated? No Yes

Are you under the care of a physician? No Yes
Name of physician:_________________________
Specialty physician:_________________________

How did you first learn about our office?
____

FAMILY MEDICAL HISTORY

			Relationship
Blindness	No	Yes	____________
Cataracts	No	Yes	____________
Glaucoma	No	Yes	____________
Diabetes	No	Yes	____________
Heart Disease	No	Yes	____________
Retinal Detachment	No	Yes	________
Macular Degeneration	No	Yes	_______

CURRENT MEDICATION

(Rx or over the counter)

			Name of medication
Antihistamines	No	Yes	_________
Diuretics(water pills)	No	Yes	_________
Blood pressure pills	No	Yes	_________
Diabetes pills/insulin	No	Yes	_________
Birth control pills	No	Yes	_________
Eye drops	No	Yes	_________

Other:__________________________________
____

Allergic to any medications? No Yes
Please list:__________________________

GENERAL HISTORY

1. Do you use alcohol? No Yes
   tobacco? No Yes
   other substance? No Yes
2. Are you frequently outdoors? No Yes
3. Are you bothered by glare outside, at work, or for night driving? No Yes ___________
4. Do you work on a computer at your job, at school, or at home? No Yes ____________
5. Do you play sports or have any hobbies?
   No Yes Please list______________
   ____
6. Have you ever worn contact lenses before?
   No Yes If yes, what type__________
   ____
7. Would you like more information on :
   -Contact lenses No Yes _________
   -Refractive surgery No Yes _________
   -Thinner, lighter lenses No Yes __________
8. Do you have a spare pair of glasses?
   No Yes

Signature (patient/guardian):

____