

WELCOME TO OUR OFFICE

PERSONAL INFORMATION			
Last Name	First Name		
Street Address			
City	State	Zip	
Home Phone: ()	Work Phone: ()	Ext.	Cell ()
Employer/School	Job Type/Grade	E-mail address	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN# or DL# - -	Birthdate (mm/dd/yy): / /	
Title: <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr. <input type="checkbox"/> Ms. Other			
Contact In Case of Emergency:		Relationship:	Phone: ()
Insurance Information (if applicable)			
Vision Plan: Medicare VSP	Other (Name)		
Medical Plan:	Insured's ID #	Group ID #	
Relationship: Self Spouse Child Other (Name)			
REFERRAL INFORMATION			
Why did you choose our office for your eyecare needs?			
<input type="checkbox"/> Another Patient (Name)		<input type="checkbox"/> Another Doctor (Name)	
<input type="checkbox"/> Insurance		<input type="checkbox"/> Other (Name)	
MEDICAL AND FAMILY HISTORY			
Reveiw of Systems		Ocular History	
Constitutional	none cold, flu, fever, tired, weight loss/gain other:	Glaucoma	None Self Mother, Father, Sibling, Grandparent
Ears, Nose, Throat	none allergy, sinusitis, congestion, hearing aids other:	Cataracts	None Self Mother, Father, Sibling, Grandparent
Cardiovascular	none hypertension, heart attack, heart surgery other:	Macular Degeneration	None Self Mother, Father, Sibling, Grandparent
Respiratory	none asthma, emphysema, bronchitis other:	"Lazy Eye"	None Self Mother, Father, Sibling, Grandparent
Gastrointestinal	none colitis, Crohns, ulcer, surgery other:	Eye Surgery	None Self Mother, Father, Sibling, Grandparent
Enodcrine	none diabetes, thyroid, hormone dysfunction other:	Other Eye Diseases	None Self Mother, Father, Sibling, Grandparent
Musculoskeletal	none arthritis, chronic fatigue, muscle pain other:	Current Medications	
Genitourinary	none kidney, bladder, prostate, STD other:	<input type="checkbox"/> List Attached	
Integumentary	none rosacea, acne, psoriasis, eczema other:	1	2
Neurological	none migraines, MS, epilepsy, Parkinsons other:	3	4
Psychiatric	none ADD, OCD, Anxiety, Depression other:	5	6
Lymphatic/Blood	none leukemia, anemia, bleeding disorder other:	7	8
		9	10
Additional Comments:			
Known Medical Allergies:			
Name of your physician(s):			
Do you Smoke? yes no How much?			