Please Print

Patient Name: ______________________________

Address: ______________________________ Apt. No: __________

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ E-Mail: ____________________

Date of Birth: ____________________ Age: ________ Sex: ( ) Male ( ) Female

( ) Single ( ) Married ( ) Minor ( ) Separated ( ) Divorced ( ) Widowed

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Employer/Occupation: ______________________________

Hobbies/Sports: ______________________________

Who can we thank for referring you to us? ______________________________

Date of last exam: ____________________ Where? ____________________

Do you wear glasses? YES NO Do you wear contact lenses? YES NO

Please bring your contact lens prescription (boxes) with you to your exam.

Please check symptoms, problems with or conditions that apply to you:

( ) Eye Injury
( ) Eye Surgery
( ) Cataracts
( ) Glaucoma
( ) Macular Degeneration
( ) Family History Cataracts
( ) Family History Glaucoma
( ) Family History Eye Disease
( ) Sensitivity to Sunlight
( ) Sensitivity to Glare at Night
( ) Headaches
( ) Head Injury
( ) Heart Condition
( ) Circulation Problems
( ) High Blood Pressure
( ) Diabetes
( ) Family History of Diabetes
( ) Digestive System
( ) Skin Condition
( ) Multiple Sclerosis
( ) Recent Illness
( ) HIV (AIDS)
( ) Tuberculosis
( ) Exposure to Eye Injury
( ) Itchy Eyes
( ) Double Vision
( ) Poor Night Vision
( ) See Spots (Floaters)
( ) See Flashes of Light
( ) Sudden Loss of Vision
( ) Dry or Burning Eyes
( ) Watery Eyes (Tearing)
( ) High Cholesterol
( ) Low Blood Sugar
( ) Breathing Problems
( ) Asthma
( ) Allergies (Hay Fever)
( ) Nose/Mouth/Throat
( ) Blood Condition
( ) Hearing Problems
( ) Cancer (Tumors)
( ) Hepatitis
( ) Pregnancy
( ) Use Illegal Drugs
( ) Drink Alcohol
( ) Use Tobacco Products
( ) Reduced Side Vision
( ) Eye Turn (Lazy Eye)
( ) Red Eye (Pink Eye)
( ) Eyestrain
( ) Computer Eyestrain
( ) Eye Pain
( ) Color Blindness
( ) Droopy Eyelids
( ) Drooping Skin above Upper Eyelids
( ) Sinus Condition
( ) Thyroid Condition
( ) Arthritis
( ) Lupus
( ) Epilepsy (Seizures)
( ) Stroke
( ) Urinary/Bowel
( ) Hormonal Condition
( ) Weight Gain or Loss
( ) Mental Disorders
( ) Muscles or Bones
( ) Sleep Disorder/Apnea
( ) Immune System

Describe additional symptoms, problems with or conditions that apply to you:

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Do you take any medications? YES NO Please list: ____________________

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Are you allergic to any medications? YES NO Please list: ____________________

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List all allergies: ______________________________

Reason For Today's Examination (Check All That Apply):

( ) General Eye Examination with No Specific Vision or Eye Health Symptoms.
( ) General Eye Examination with Difficulty Seeing at Distance, Intermediate or Near. (with glasses or contact lenses when worn)
( ) Contact Lens Examination or Evaluation of Current Contact Lenses.
( ) Information on Refractive (Corrective Laser Eye) Surgery.
( ) Eye Health Symptom(s) or Problem(s) with Vision (Please Explain Below):

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Patient Information on Vision Eye Examinations and Medical Eye Health Evaluations:

Vision eye examinations provide for a basic eye health evaluation as well as determine if glasses or contact lenses are needed to improve your vision. Medical eye health evaluations consist of specific testing/procedures to evaluate and determine if a medical eye health condition or general medical condition is present that requires treatment, monitoring or referral to another doctor or facility. The type of examination you need is based on your visual symptoms, visual and eye health history, medical history, medications you take as well as any clinical observation where we feel that there may be something seriously wrong with the health of your eyes or your general health. **NOTE:** Vision insurance does not cover medical eye health evaluations and medical insurance does not cover vision eye examinations.

Our Recommendations for Vision Eye Examinations:

Retinal Photography: Photographs of the back of the eye to aid in detecting glaucoma, diabetes, high blood pressure, high cholesterol and macular degeneration. **COST: $20.00**
Would you like this test? ( ) YES ( ) NO

Dilated Eye Health Examination: Eye drops are placed in the eyes to temporarily enlarge the pupils to allow for a complete evaluation of the internal eye structures. Dilation will blur your vision and cause light sensitivity for a few hours. There is no additional cost for patients who get retinal photography. **Would you like this procedure? ( ) YES ( ) NO**

Patient Information: Release of information will only be done if relevant to your treatment, office fees, insurance requirements and/or general operations of this office. A copy of HIPPA will be provided on request. It is your responsibility to keep all appointments and referrals. If you have any questions, please ask.

Patient Signature: ______________________________ Date: ____________________