PLEASE HELP US KEEP OUR RECORDS CURRENT

DATE: _____/_____/_____

(Circle One)

Mr. Mrs. Last Name: ____________________ First Name: _________________________ MI: _____________

Miss Ms. Street Address: ____

City: _________________________ State: ____________________ Zip Code: _____________

NP

Telephone: (H) _______________ (W) ________________ (Mobile) _____________________

Occupation: _________________________ Birthdate: _____/_____/_____ Age: ___________

FP

Hobbies/Sports: ____

Referred by: **(NEW PATIENTS ONLY)** ____

Please answer the following questions:

1. Are you having problems seeing at: Distance? Reading? Computer? Other?
2. Are you planning to select new glasses today? _____________ (Y/N/?)
3. Are you planning on ordering contact lenses today? _________ (Y/N/?)
4. Do you want to have an Optomap scan done today? _________ (Y/N/?)

FOR OFFICE USE ONLY VSP PVT MC MES OTHER Y K C

CAT GLC RD AMD DM HTN ARCUS Dx: Hyper/>3 Myope/>6 A/>2 Presbyope Emmetrope

EXAM ONLY Rx: SV BIF TRIF NPROG PROG CL (DIS S TORIC COLOR DW EW) GP CRT

FRAME: LENS MATERIAL: PL PC TX MID HI IZON

Change of Address Outside Rx No Recall Frame Only Repair Only Lens Only

MEDICAL HISTORY RECORD

☐ Former patients: Please check box if there has been any changes since your last eye examination and fill out the appropriate changes below.

New patients, please complete the entire form to the best of your knowledge.

Date of Last Eye Exam: _____/_____/______ Name of Previous Eye Doctor: _________________________

Eye information: Do you have any of the following eye problems? If yes, please check box.

☐ Dry ☐ Itchy ☐ Red ☐ Watery ☐ Gritty ☐ Discharge ☐ Flashes/Floaters

☐ Tired eyes ☐ Ache/Sore ☐ Pain ☐ Pressure ☐ Seasonal Allergies ☐ Burning

Have you had any previous eye infection, injury, or disease? ☐ Yes ☐ No

If yes, please describe: ____

List any prescription **OR** over-the-counter eye drops you currently take: ____

Personal Medical Information: Do you have any problems with any of these systems? If yes, please check box.

☐ Cardiovascular ☐ Endocrine (Glands) ☐ Respiratory ☐ Gastrointestinal

☐ Allergic/Immunologic ☐ Blood Lymph ☐ Ear/Nose/Throat ☐ Genitourinary

☐ Musculoskeletal ☐ Integumentary ☐ Nervous ☐ Mental

List the names of any medications you take and the amount: ____

____

List any drug allergies:____

Have you had any previous significant illness, accident, or trauma? ☐ Yes ☐ No

If yes, please describe: ____

Date of Last Physical Exam: _____/______/_____ Name of General Physician:_______________________________

Social History: ***This information is strictly confidential. However, you may discuss this portion directly with your doctor.***

Do you smoke? ☐ Yes ☐ No How much? ____

Do you drink alchohol? ☐ Yes ☐ No How much? ____

Do you use other substances? ☐ Yes ☐ No

Family History: Do you have a family history of any of the following? If yes, please check box.

☐ Glaucoma ☐ Retinal Detachment ☐ Macular Degeneration ☐ Cataract

☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Autoimmune

Please explain any boxes you have checked: ____