## 

| Name  |   |   |  | Ma /Miss (sirals and)  | Today's  | 1 1   |
|---|---|---|--|--|--|---|
| First Middle Ini  | tial  | Last  |  | Ms./Miss (circle one)  | Date   | //  |
| Address   |   |   | Ci   | ty   | State  | Zip   |
| Communication Preference: Phor  | ie Postal   | Email 1   | Text E   | E-Mail Address   |  |   |
| Cell Phone ()   |   |   |  |  |  |   |
| Date of Birth//   | Age_  | Se  | x: <b>M</b> / I                                  | F Height W   | eight  | _   |
| Race  |   |   |  |  |  |   |
| Vision Insurance <b>Yes / No</b> Plan Nar   |   |   |  |  |  |   |
| Social Security Number  |   | Occupa  | ation  |  | Employer   |   |
| Are you interested in learning more   | about our C   | areCredit hea   | althcare   | financing program? Yes / N   | No   |   |
| Do you use a computer? Yes / No   | How man   | y hours a da  | ıy?  |  |  |   |
| What hobbies or sports do you parti   | cipate in? _  |   |  |  |  |   |
| Have you been a patient in this office  | e before?   | Yes / No  | How did  | you hear about us?   |  |   |
| Date of last Eye Exam   |   |   |  | Date of last Phys  | ical Exam  | <i></i>   |
| Do you use cigarettes / tob   | acco? Yes   | / No  |  | If female, are you   | ı pregnant or nu   | rsing? Yes / No   |
| What is the main reason for today's   | visit?  |   |  |  |  |   |
|   |   |   |  |  |  |   |
| Describe any EYE or VISION proble   | ems you exp   | erience (Blur   | rred Visio                                       | on, Eye Pain, Double Vision, F   | lashes, Floaters   | s, Dryness, Allergies   |
|   |   |   |  |  |  |   |
| Do you wear GLASSES? Yes / No   | CONT  | TACT LENSE  | ES? <b>Yes</b>                                   | / No Are you intereste   | d in trying conta  | ct lenses? Yes / No   |
| List any previous EVE Injuries Dis  | eases. or S   | urgeries  |  |  |  | None  |
| List arry previous LTL injuries, Dis  | <b>,</b>  |   |  |  |  |   |
|   |   |   |  |  |  |   |
| List ANY medications you currently  |   |   |  |  |  |   |
|   |   |   |  |  |  |   |
|   | take (includi   | ng birth conti  | rol or vita                                      | amins):  |  | None  |
| List ANY medications you currently  List ANY medications you are allerg   | take (includii  | ng birth contr  | rol or vita                                      | amins):  |  | None<br>None  |
| List ANY medications you currently  | take (includii  | ng birth contr  | rol or vita                                      | amins):  |  | None  |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  | ic to<br>Self Family, h   | ng birth contr  | rol or vita                                      | emins):  ving? (Check all that a   | apply. Check her   | None None re if none apply)   |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Turned or Lazy Eye  | ic toself Family  | ng birth control  | rol or vita                                      | ving? (Check all that a  | apply. Check hel   | None None re if none apply) ry Tract Disease  |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Turned or Lazy Eye  Cataract  | ic to   | ng birth contr<br>ad any of the<br>Arthritis<br>Cancer  | rol or vita                                      | ving? (Check all that a  | apply. Check hell Self Family Urina Anxie  | None None re if none apply) ry Tract Disease ty   |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Turned or Lazy Eye Cataract Glaucoma Macular Degeneration   | ic to   | ng birth control  and any of the  Arthritis Cancer  Kidney Disea Lupus  | rol or vita                                      | wing? (Check all that a Self Family Sinus Problems Ear Infections Autoimmune Disease   | Self Family Urina Anxie  | None None re if none apply) ry Tract Disease ty ession Condition  |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Turned or Lazy Eye Cataract Glaucoma Macular Degeneration Retina Problems   | ic to   | ng birth control  and any of the  Arthritis Cancer  Kidney Disea Lupus Stroke   | ne follow  | wing? (Check all that a Self Family Sinus Problems Ear Infections Autoimmune Disease Blood Disorder /  | Self Family Urina Anxie  | NoneNone re if none apply) ry Tract Disease ty ession Condition ach   |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Turned or Lazy Eye Cataract Glaucoma Macular Degeneration Retina Problems Diabetes  | ic to   | ng birth control  and any of the  Arthritis Cancer  Kidney Disea Lupus Stroke Thyroid Disea                                 | ne follow  | semins):  (Check all that a Self Family Self Family Sinus Problems Ear Infections Autoimmune Disease Blood Disorder / Anemia   | Self Family Urina Anxie Depre  | NoneNone Te if none apply)  Try Tract Disease ty ession Condition ach   |
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| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Turned or Lazy Eye  Cataract  Glaucoma  Macular Degeneration  Retina Problems  Diabetes  High Blood Pressure  | stake (including ic to  | ng birth control  and any of the  Arthritis Cancer  Kidney Disea Lupus Stroke Thyroid Disea Asthma                          | ne follow  | semins):  (Check all that a Self Family Self Family Sinus Problems Ear Infections Autoimmune Disease Blood Disorder / Anemia Headaches   | Self Family Urina Anxie Depre  | NoneNone None  re if none apply)  ry Tract Disease ty ession Condition ach I blogical Disease Medical                                     |
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| List ANY medications you currently  List ANY medications you are allergy  Have you, or any of your immedia  Self Family  Cataract Glaucoma Glaucoma Hacular Degeneration Retina Problems Glabetes High Blood Pressure High Cholesterol Heart Disease  * Please explain  INF I authorize any holder of my person   | stake (including ic to  | ng birth control  and any of the  Arthritis Cancer Kidney Disea Lupus Stroke Thyroid Disea Asthma COPD Allergies  Allergies | ne follow use  CONSER mation to ut me to HIPPA o | self Family  Self Family Sinus Problems Ear Infections Autoimmune Disease Blood Disorder / Anemia Headaches Seizures HIV or other STD  So release information about me other healthcare providers, atter other legal requirements.                     | Self Family Urina Anxie Depre Skin Skin Neuro Cond                                 | None None  None  re if none apply)  ry Tract Disease ty ession Condition ach I blogical Disease Medical ition  are and I authorize        |
| List ANY medications you currently  List ANY medications you are allerg  Have you, or any of your immedia  Self Family  Cataract Glaucoma Macular Degeneration Retina Problems Diabetes High Blood Pressure High Cholesterol Heart Disease  * Please explain  INF I authorize any holder of my personage Eyecare to release medical   | stake (including ic to  | ng birth control  and any of the  Arthritis Cancer Kidney Disea Lupus Stroke Thyroid Disea Asthma COPD Allergies  Allergies | ne follow use  CONSER mation to ut me to HIPPA o | self Family  Self Family Sinus Problems Ear Infections Autoimmune Disease Blood Disorder / Anemia Headaches Seizures HIV or other STD  So release information about me other healthcare providers, atter other legal requirements.                     | Self Family Urina Anxie Depre Skin Skin Neuro Cond                                 | None None  None  re if none apply)  ry Tract Disease ty ession Condition ach I blogical Disease Medical ition  are and I authorize        |