Patient Form: (Please print neatly)

Last Name :_____ **First:**_____ **MI:**___
Address:_____
_____
Tel #:_____**Email:**_____
Date of Birth:_____**Age**_____ **Sex: M / F**
Race: ☐ White ☐ African American
☐ Hispanic ☐ Asian/Pacific Islander
☐ Other _____
Language Preference:_____

Will you be using vision insurance today? Yes / No
If yes, please fill Vision Insurance Information section below.

Vision Insurance Information:
Vision Insurance: VSP / EyeMed / MES / Other_____
Member ID:_____
Policy Holder's Name$_{(Last,First)}$:_____
Policy Holder's Date of Birth:_____
Last 4 digits of Social Security number:_____
Relationship to Patient:_____

Purpose of Visit:_____
_____

Medical History:
Have you ever been diagnosed or treated for any of the following health problems?

Allergies	_____	Yes / No / Family _____
Asthma/Respiratory	_____	Yes / No / Family _____
Arthritis	_____	Yes / No / Family _____
Blood/Lymph	_____	Yes / No / Family _____
Cancer	_____	Yes / No / Family _____
Cholesterol	_____	Yes / No / Family _____
Diabetes	_____	Yes / No / Family _____
Digestive/Gastric	_____	Yes / No / Family _____
Ears/Nose/Throat	_____	Yes / No / Family _____
Endocrine	_____	Yes / No / Family _____
Fatigue	_____	Yes / No / Family _____
Fevers	_____	Yes / No / Family _____
Heart Disease	_____	Yes / No / Family _____
High Blood Pressure	_____	Yes / No / Family _____
Immune	_____	Yes / No / Family _____
Integumentary (Skin)	_____	Yes / No / Family _____
Kidney	_____	Yes / No / Family _____
Muscle/Bone	_____	Yes / No / Family _____
Neurological/Headaches	_____	Yes / No / Family _____
Psychological	_____	Yes / No / Family _____
Stroke	_____	Yes / No / Family _____
Thyroid Problems	_____	Yes / No / Family _____
Unusual Weight Loss/Gain	_____	Yes / No / Family _____

Primary Physician Name:_____
Date of Last Physical:_____

Occupation:_____
Current Medications:_____
_____
_____
Are you allergic to any medications? YES / NO
If yes, please identify them below.
_____
_____
Are you pregnant or nursing? YES / NO

History of eye injuries/surgeries? YES / NO
If yes, please explain below.
_____
_____

Social History:
Do you smoke/drink alcohol? YES / NO
Frequency:_____

Ocular History:
Last Eye Exam_____ Last Eye Dilation_____
Have you ever experienced, been diagnosed or treated for any of the following?

☐	Blurry Vision	☐	Night Vision Problem
☐	Flash of Light	☐	Lazy Eye
☐	Itchy Eyes	☐	Crossed Eye/Eye Turn
☐	Teary	☐	Cataracts
☐	Pain	☐	Glaucoma
☐	Floaters	☐	Macular Degeneration
☐	Dry Eyes	☐	Retina Detachment
☐	Light Sensitivity	☐	Headaches
☐	Inflammation	☐	Freq Neck/Shoulder Pain
☐	Eye Infection	☐	Other Eye Disorders

_____

Family Ocular History:
Is there a family medical history of the following?

Blindness	Yes / No	_____
Diabetic Retinopathy	Yes / No	_____
Cataracts	Yes / No	_____
Glaucoma	Yes / No	_____
Eye Turn/Lazy Eye	Yes / No	_____
Macular Degeneration	Yes / No	_____
Retinal Problems	Yes / No	_____

Visual Need Assessment:
Hours of computer usage:_____
Hours of outdoor activities:_____
Hours before reading fatigue:_____
Hobbies:_____
Sports:_____

Are you interested in looking at eyeglasses today?
Yes / No

Patient Verification
The patient history information that I have provided above is accurate and complete to the best of my knowledge.
Signature (If under 18 years of age, parent/guardian signature required):_____ **Date:**_____