

# Welcome to Our Clinic

Today's Date:

PATIENT INFORMATION FORM							
Last Name		First Name		Birthday		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City		State		Zip	
Email Address		Home Phone			Work Phone		
Method of Payment <input type="checkbox"/> Cash <input type="checkbox"/> Credit Card <input type="checkbox"/> Insurance							
Occupation		Insurance Company					
MEDICAL HISTORY							
Do you have problems with any of the following? (Please circle Y for yes and N for no)							
Gastrointestinal	Y/N	Genitourinary	Y/N	Blood /Lymph	Y/N	Med allergy	Y/N
Ears/Nose/ Throat	Y/N	Musculoskeletal	Y/N	Allergic / Immunologic	Y/N	Headaches	Y/N
Cardiovascular	Y/N	Integumentary (skin)	Y/N	Diabetes	Y/N		Y/N
Respiratory	Y/N	Mental	Y/N	High Blood Pressure	Y/N		
Nervous	Y/N	Endocrine(glands) including Thyroid		Y/N			
Have you had any operation?		Y/N	Kind?	When?			
Do you use cigarettes/tobacco?		Y/N	Alcohol?	Y/N	Other substances?		Y/N
Name of family doctor: _____				Date of last visit? _____			
Date of last tetanus shot?							
List any other medical condition you are being treated for:				List medications you are taking(including)birth control)			
Is there a family history of any of the following? (Please circle Y for yes and N for no and list relation for Y answers)							
High Blood Pressure		Y/N		Retinal Detachment		Y/N	
Diabetes		Y/N		Cataracts		Y/N	
Heart Problems		Y/N		Glaucoma		Y/N	
Macular Degeneration		Y/N		Other Eye Conditions		Y/N	
EYECARE HISTORY							
Headaches		Y/N		Itching		Y/N	
Floaters		Y/N		Burning		Y/N	
Flashes		Y/N		Tearing		Y/N	
Red Eyes		Y/N		Seeing Double		Y/N	
Pain in Eyes		Y/N		Crossed Eyes		Y/N	
Eye Infections		Y/N		Amblyopia (Lazy eye)		Y/N	
Dry Eyes		Y/N		Had Vision Therapy		Y/N	
Date of Last Eye Exam:		By whom?			Are you on a computer? Y/N		
					If So, how many hours per day?		
Do you currently wear glasses?		Y/N		When and where were they purchased?			
Have you worn contact lenses?		Y/N		<input type="checkbox"/> Rigid	<input type="checkbox"/> Soft	<input type="checkbox"/> Disposable	<input type="checkbox"/> Daily wear
				<input type="checkbox"/> Extended wear	<input type="checkbox"/> Tinted		
Do you want contact lenses?		Y/N		<input type="checkbox"/> Rigid	<input type="checkbox"/> Soft	<input type="checkbox"/> Disposable	<input type="checkbox"/> Daily wear
				<input type="checkbox"/> Extended wear	<input type="checkbox"/> Tinted		
HOW DID YOU HEAR ABOUT OUR OFFICE?							
<input type="checkbox"/> Referral	<input type="checkbox"/> Mail out	<input type="checkbox"/> Recall card	<input type="checkbox"/> Walk-In	<input type="checkbox"/> Insurance	<input type="checkbox"/> Internet	<input type="checkbox"/> Other (List Below)	
Whom may we thank for telling you about our practice?							
Address							
City				State		Zip	
Form: (0801) Patient Information Form				Doctor's Initials			