

PATIENT HISTORY AND GENERAL INFORMATION
(Confidential information necessary to complete or update our files)

Dr. Mrs.
 Mr. Miss
 Ms. Name: _____ Date of Birth: _____

Address _____ City/State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Best to reach you by (List 1, 2, 3) Home Work Cell E-Mail _____

Occupation _____ Employer _____ Social Security # _____

Marital Status _____ Name of Spouse _____ Name of parent if under 21 _____

Who may we thank for referring you? _____

Type of VISION CARE Insurance: VSP MES NONE OTHER _____ Primary Person Insured _____

Type of MEDICAL Insurance: Blue Cross Blue Shield Medicare None Other _____ Secondary _____

Approximate date of last eye examination _____ Doctor _____

Have you noticed any changes in your vision? _____ Distance/Near/Both/Other _____

How old is your current prescription? Glasses _____ Contact Lenses _____

How long have you been wearing Glasses _____ Contact Lenses _____

Please list any specific visual tasks for your occupation & hobbies (computer, reading, sewing, desk work, sports etc.)

How is your general health? _____ Date of last physical exam _____

Name of Physician _____ City _____ Phone _____

Has anyone in your family ever had any eye problems relative to:

- | | | |
|---|--|---|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ |

Do you have (or had in the past) any medical conditions?

- | | |
|--|---|
| <input type="checkbox"/> Allergies, Seasonal or Drug | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye Disease/Injury |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Headaches: how often _____ | <input type="checkbox"/> Other _____ |

Please list any medications you are taking.

Any comments: _____

Signature _____ Date _____

Returning Patients only:

- | | |
|--|------------|
| <input type="checkbox"/> No Changes in the above information. Sign _____ | Date _____ |
| <input type="checkbox"/> No Changes in the above information. Sign _____ | Date _____ |
| <input type="checkbox"/> No Changes in the above information. Sign _____ | Date _____ |