PATIENT INFORMATION (BE SURE TO COMPLETE AND SIGN BOTH SIDES) 309

Last Name_____ First_____ Middle In._____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone_____ - _____ Work Phone_____ - _____ Cell_____- _____

Your **Email**_____ May we use your email to contact you. † YES † NO

SS#_____ Occupation_____ Date of Birth_____

Primary Doc_____ His/Her Email or Phone # _____

Referred by: _____ Found Online:† VSP† Insurance Website† Other Web

Emergency contact Name:_____ Phone:_____

Due to new Federal Regulations we ask that you provide us with the following information:

Marital Status_____ Race_____ Ethnicity_____

Medications:_____
(You may want to provide us with a list of your medications for us to copy).

Medication Allergies:_____

Reasons for Today's Visit

† **Comp. Eye Health and Vision Exam**
† LASIK Evaluation
† Blurred Dist, V
† Blurred Near, V
† **Contact lens evaluation**, V
† Scratched eye, O
† Allergies, itching, O
† Double Vision, O
† Eye Turn, O
† Field loss, O
† Floaters / Flashes, O
† Foreign Body, O
† Headaches/ Migraine, S
† Lumps / Bumps, O
† Pain, O
† Red Eye? Dry Eyes O
† Trauma / Burn, O,S

Your General Health (ROS)

† **All Okay, No Exceptions**
† All Okay, Except
† Allergies
† Cardiovascular (hypertensive)
† Constitutional
† Endocrine (diabetes)(thyroid)
† Gastrointestinal
† Genitourinary
† Head/ ENT/ Dental
† Hematologic / Lymph
† Immunologic
† Integumentary (skin)
† Musculoskeletal (arthritis)
† Neurological
† Psychiatric
† Respiratory
† Other

You orYour Family

† **All Okay, No Exceptions**
† All Okay, Except
† Retinal Holes or Tears
† Keratoconus
† Dry Eyes
† Laser Surg.
† Eye Surg.
† Color Defect
† Transplant
† Herpes
† Rheumatoid
† HIV+
† Glaucoma
† Macular Degeneration
† Diabetes

Your last eye exam: _____ yr(s)

Social History:

Do you smoke? † Yes † No † Former How often? _____
Do you drink (even wine)? † Yes † No † Socially How often? _____
Do you use drugs? † Yes † No † Rehab How often? _____

"**All the above is true to the best of my knowledge." Sign**_____ **Date**_____

Please provide us with your medical health and vision care insurance cards for us to copy.