GETTING TO KNOW YOU

DEMOGRAPHICS

LAST NAME:	FIRST NAME:	BIRTH DATE: / /	AGE:
ADDRESS:	CITY:	STATE:	ZIP:
HOME #:	CELL #:	WORK #:	SEX: ☐ F ☐ M
E-MAIL:	DATE OF LAST EXAM: / /	LOCATION:	
EMPLOYER:	OCCUPATION:		
WHOM MAY WE THANK FOR REFERRING YOU?			

INSURANCE

VISION INSURANCE PLAN NAME:	GROUP #:	ID #:
PRIMARY INSURED NAME:	PRIMARY INSURED DOB: / /	RELATIONSHIP:
INSURED EMPLOYER:	INSURED ADDRESS:	
INSURED SOCIAL SECURITY #:	(IF DIFFERENT)	

VISION

WHAT IS THE REASON FOR TODAY'S EXAM?	
ARE YOU PLANNING TO GET NEW GLASSES TODAY? ☐ Yes ☐ No	NEW CONTACTS TODAY? ☐ Yes ☐ No
AGE OF PRESENT GLASSES:	AGE OF PRESENT SUNGLASSES: ☐ RX ☐ NON-RX

HEALTH HISTORY

DO YOU OR ANY OF YOUR BLOOD RELATIVES (PARENTS, GRANDPARENTS, BROTHER, OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE
DIABETES	☐	☐	☐	GLAUCOMA	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	CATARACTS	☐	☐	☐
HEART DISEASE	☐	☐	☐	MACULAR DEGENERATION	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	RETINAL DISEASE	☐	☐	☐
THYROID DYSFUNCTION	☐	☐	☐	EYE SURGERY	☐	☐	☐
ARTHRITIS	☐	☐	☐	EYE INJURY	☐	☐	☐
ASTHMA	☐	☐	☐	BLINDNESS	☐	☐	☐
CANCER	☐	☐	☐	OTHER:	☐	☐	☐
OTHER:	☐	☐	☐				

	YES	NO		YES	NO
FREQUENT HEADACHES?	☐	☐	HAVE YOUR EYES BEEN DILATED?	☐	☐ YEAR?____
ARE YOU PREGNANT?	☐	☐	DO YOU SEE DOUBLE?	☐	☐

PRIMARY CARE DOCTOR:

ARE YOU TAKING ANY MEDICATIONS (PRESCRIPTIONS OR OVER THE COUNTER)? PLEASE LIST:

DO YOU USE ANY EYE DROPS (PRESCRIPTION OF OVER THE COUNTER)? PLEASE LIST:

DO YOU HAVE ALLERGIES TO MEDICATIONS, SOLUTIONS, OR OTHER? PLEASE LIST:

PATIENT / LEGAL GUARDIAN SIGNATURE: _____ DATE: ___/___/_____