PATIENT INTAKE FORM

We are pleased you have chosen our office for your vision and eye care. We will strive to provide you with the most modern, professional services and appropriate care. If you have any questions about your examination or care provided, or if you have any suggestion, please feel free to discuss it with one of our staff or our doctor.

Date
Social Security #
Patient Name
Birthdate
Address
City
Zip
Daytime Phone
Evening Phone
Cell Phone
Email Address
Drivers License #
Employer
Occupation
Parent/Guardian if minor
Family Members

IT IS THE POLICY OF OUR OFFICE THAT PAYMENT IS DUE AT TIME OF SERVICE.

Name of Vision Insurance
Name of Policy Holder
Medicare # (if applicable)
Supplemental Insurance

MEDICAL HISTORY QUESTIONNAIRE

This form is critical for the doctor to thoroughly evaluate your vision and health.
Please completely fill out all pages. Thank you.

PERSONAL MEDICAL HISTORY

Date of last physical exam
Name of physician
Date of last vision exam
Name of eye doctor

List all medications you are currently taking (i.e. oral contraceptives, aspirin):

Do you have any allergies or allergies to medications? Y/N If yes, please explain:

Do you have a history of any eye diseases/conditions? Y/N If yes, please explain:

Do you wear glasses or contact lenses? Y/N If yes, which do you wear and how old is the current pair?

FAMILY MEDICAL HISTORY

Please list the family member(s) with the following medical conditions:

Disease/Condition		Family member (i.e. mother, paternal grandfather, etc)
Blindness	Y/N	
Lazy Eye	Y/N	
Glaucoma	Y/N	
Macular Disease	Y/N	
Retinal Disease	Y/N	
Arthritis	Y/N	
Diabetes	Y/N	
Heart Disease	Y/N	
Hypertension	Y/N	
Thyroid Disease	Y/N	
OTHER	Y/N	

SOCIAL HISTORY

Please circle. If you answer yes, please explain.

System	Y/N	Not Sure	Explanation/Medications
I. Integumentary			
1. Skin Problems	Y/N	?	
II. Neurologic			
1. Headaches/Migraine	Y/N	?	
2. Seizures	Y/N	?	
III. Eyes			
1. Loss of Vision	Y/N	?	
2. Double Vision	Y/N	?	
3. “Pink”/Red Eye	Y/N	?	
4. Light Sensitivity	Y/N	?	
5. Eye Pain	Y/N	?	
6. Eye Infections	Y/N	?	
7. Eye Diseases	Y/N	?	
8. Watery Eyes	Y/N	?	
9. Dry Eyes	Y/N	?	

SOCIAL HISTORY (...continued)

System	Y/N	Not Sure	Explanation/Medications
IV. Ears, Nose, Mouth, Throat			
1. Allergies	Y/N	?	
2. Hay Fever	Y/N	?	
3. Sinus Congestion	Y/N	?	
4. Runny Nose	Y/N	?	
5. Dry Throat/Mouth	Y/N	?	
6. Ear Infection	Y/N	?	
V. Respiratory			
1. Asthma	Y/N	?	
2. Chronic Bronchitis	Y/N	?	
3. Emphysema	Y/N	?	
VI. Vascular			
1. Diabetes	Y/N	?	
2. High Blood Pressure	Y/N	?	
3. Vascular Disease	Y/N	?	
VII. Gastrointestinal			
1. Diarrhea	Y/N	?	
2. Constipation	Y/N	?	
VIII. Genitourinary			
1. Genitals	Y/N	?	
2. Kidney/Bladder	Y/N	?	
IX. Bones/Joints/Muscles			
1. Rheumatoid Arthritis	Y/N	?	
2. Muscle/Joint Pain	Y/N	?	
X. Lymphatic/Hematological			
1. Anemia	Y/N	?	
2. Bleeding Problems	Y/N	?	
XI. Endocrine			
1. Thyroid/Other	Y/N	?	
XII. Psychiatric			
1. Anxiety/Depression	Y/N	?	
XIII. Constitutional			
1. Fever	Y/N	?	