

WELCOME BACK TO



Professional Family Eyecare

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Cell Phone _____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Date of Birth _____ Age _____

Sex M F

Email Address _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Phone) _____

What is the major purpose of this visit?

Do you have any problems with your current contact lenses or glasses?

Have you experienced any of the following?

Eye Injury Burning

Double Vision Itchiness

Flash of light Tearing

Floaters/Spots

Other eye disorders _____

Do you currently wear contact lenses? Yes No

What kind? _____

Solutions used _____

Do you sleep in your contact lenses? Yes No

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes

No

Lifestyle Questions

Do you.....(check box if your answer is yes)

..work at a computer?

..think you might benefit from thinner, lighter lenses?

..have interest in a "test drive" of the latest contact lens designs?

..spend time outdoors? How much? ___Hrs/week

..participate in sports? Which ones? _____

..have prescription sunwear?

..prefer not to wear your glasses at times?

..have more than 1 pair of current eyewear?

..wear bifocals? Do lines or head-tilting bother you?

..want information on Laser Vision Correction surgery?

Patient Medical History

CURRENT MEDICATIONS - Rx and Over the Counter (List name of medications including eye drops, vitamins, & birth control pills) _____

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>