



EYE CONTACT

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Daytime Phone _____

Date of Birth _____ Sex M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

Date of Birth _____ Sex M F

Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

The doctors and staff of Eye Contact are fully committed to you and your families complete vision wellness. Our patients' visual needs are our highest priority. We are committed to providing state-of-the-art vision care, the finest eyewear products available in an atmosphere of uncompromised services, value, and friendliness.

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN or ID# _____

Subscriber Birth Date _____

Relationship to subscriber

- Self Spouse Child

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID# & Group# _____

Subscriber Birth Date _____

Relationship to subscriber

- Self Spouse Child

Do you participate in a flex spending account?

- Yes No

How will you settle your account today?

- Cash Check Credit/Debit

Lifestyle Questions

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

- Work at a computer? How many hrs/day? _____
- 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
- Have prescription sunwear?
- Prefer not to wear your glasses at times?
- Want information on Laser Vision Correction surgery?
- Have interest in a non-surgical approach to vision correction?
- Have more than 1 pair of current RX eyewear?
- Have children?
- Have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses | |
| <input type="checkbox"/> Other eye disorders _____ | |

This information in this confidential case history form is critical to the evaluation of your vision and health

Patient Medical History

Name of Family Physician _____

Town _____

Date of Last Physical Check-up _____

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

Allergies to medications? Yes No

If so, what medications? _____

Have you had any surgeries? Yes No

Do you use cigarettes, tobacco, alcohol, or other substances? Yes No

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"/>
Bronchitis	<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"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<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"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History

Date of last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No

What kind _____
Solutions used _____

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

Do you prefer clear or colored contact lens?
 Clear Colored

If you wear bifocals, do the lines or head tilting bother you? Yes No

Family Med/Eye History (Check all that apply)

Is there a family medical history of any of the following: No Yes (please check boxes)

	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____



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