

**WELCOME TO OUR OFFICE** (610)

The following information is required by insurance and allows us to provide you with the best care possible.

Today's Date: \_\_\_\_\_

Name: Mr Mrs Miss Ms Dr \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip code \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

e-mail \_\_\_\_\_

Marital Status: (please circle) S M D W

M F Gm Gf Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

M F Gm Gf Drivers License # \_\_\_\_\_

Occupation (or grade) \_\_\_\_\_

Employer (or school) \_\_\_\_\_

Emergency contact: \_\_\_\_\_

and telephone #(s): \_\_\_\_\_

Whom may we thank for referring you to our office?  
\_\_\_\_\_

Family members living at home: (please list names and ages) \_\_\_\_\_

How will you settle your account today?  
(please circle) Cash Check Credit Card

**PERSONAL/ FAMILY MEDICAL HISTORY**

Are you pregnant or nursing? No Yes

Do YOU or your IMMEDIATE family have (please circle)

Arthritis .....	Self	Parent	Bro/Sis	Child	No
Cancer	Self	Parent	Bro/Sis	Child	No
Diabetes .....	Self	Parent	Bro/Sis	Child	No
Heart Disease	Self	Parent	Bro/Sis	Child	No
High Blood Pressure	Self	Parent	Bro/Sis	Child	No
Thyroid Disease.....	Self	Parent	Bro/Sis	Child	No
Skin Disorder	Self	Parent	Bro/Sis	Child	No
Asthma	Self	Parent	Bro/Sis	Child	No
Allergies.....	Self	Parent	Bro/Sis	Child	No
Eye Disease/Injury	Self	Parent	Bro/Sis	Child	No
Eye Surgery	Self	Parent	Bro/Sis	Child	No
Lazy Eye .....	Self	Parent	Bro/Sis	Child	No
Cataracts	Self	Parent	Bro/Sis	Child	No
Glaucoma .....	Self	Parent	Bro/Sis	Child	No
Macular Degeneration	Self	Parent	Bro/Sis	Child	No
Blindness	Self	Parent	Bro/Sis	Child	No

Other (please list) \_\_\_\_\_

Please list any major hospitalizations, surgeries, or injuries you have had \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Specialist: \_\_\_\_\_ for \_\_\_\_\_

**PERSONAL SOCIAL HISTORY**

Do you use tobacco products? No Yes

Do you drink alcoholic beverages? No Yes

Do you use illegal drugs? No Yes

**CURRENT MEDICATION** (by prescription or OTC)

			Name of medication
Cholesterol pills	No	Yes	_____
Blood pressure pills	No	Yes	_____
Diabetes pills or insulin	No	Yes	_____
Thyroid pills	No	Yes	_____
Birth control pills	No	Yes	_____
Antihistamine/Allergy	No	Yes	_____
Eye drops	No	Yes	_____

**Please list other medications** \_\_\_\_\_

Are you allergic to any medications? No Yes

If so, please list \_\_\_\_\_

**EYE / VISION HISTORY**

Do you experience, or have you experienced...

1. Blurry vision, Loss of vision, Double vision? No Yes
2. Halos / Glare / Light Sensitivity? No Yes  
outside at work night driving other
3. Itchy/Dry/Stinging/Gritty/Sore/Tired eyes? No Yes
4. Watery or Mucous discharge? No Yes
5. Red eyes or Eyelid infections No Yes
6. Flashes of light or Floating spots No Yes
7. Headaches No Yes

Are you on a computer at (circle) work home school

Please list sports you play \_\_\_\_\_

Please list hobbies \_\_\_\_\_

Have you worn contact lenses before? No Yes

If yes, what type? \_\_\_\_\_

Are you interested in wearing contacts now? No Yes

Are you interested in LASIK? No Yes

Would you like thinner, lighter lenses for glasses? No Yes

Do you have a back-up pair of glasses? No Yes

Do you have sunglasses? (circle) w/prescription w/oRx None

Please list any other concerns that you may have regarding your eyes \_\_\_\_\_

I hereby assign all insurance benefits to Family Optometric Group, and understand I am financially responsible for all charges (whether or not they are covered by insurance) and any service charges (18%).

M F Gm Gf Signature \_\_\_\_\_