Patient Information Today's Date: _____

Name: _____ Birthdate: _____Gender/Personal Pronoun: _____

Address: _____ City: _____ State: _____Zip: _____

Home Phone:_____Work: _____Cell:_____Text: Y N

Martial Status:_____Last 4 digits of SS#: _____email:_____

Employment Status: Full-time Part-time Student Not employed Retired

Occupation:_____Employer: _____

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Primary Health Insurance: _____Secondary:_____

Vision Plan:_____

Responsible Party (if minor or primary on insurance plan):_____

Address: _____ City: _____ State: _____Zip: _____

Home Phone:_____Work: _____Cell:_____

Birthdate:_____Relationship: _____Last 4 digits of SS#: _____

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New Patients and/or existing contact lens patients

Previous eye doctor: _____

Date of last eye examination: _____Here? Yes No

| | | | |
|---|---|---|---|
| Do you wear glasses? | Yes No | | |
| Were glasses purchased at this location? | Yes No | | |
| Do you have your glasses with you? | Yes No | If yes, do they need to be updated? | Yes No |
| Do you have sunglasses? | Yes No | Are you interested in prescription sunglasses? | Yes No |
| Do you wear contacts? | Yes No | If yes, how many years? _____<br>If no, are you interested in being examined for contacts today? | Yes No |
| How often do you replace your contacts? | | | |
| Max # of hours wearing in a day? | | | |
| Hours wearing today? | | If not, last time you wore them? | |
| Do you sleep in your contacts? | Yes No | 1 night, 1 week, 2 weeks, 1 month | |
| Are your contacts comfortable? | Yes No | | |
| Any vision issues with your contacts? | Yes No | If yes, distance or near? | |
| Brand of multipurpose solution? | | | |
| Do you use drops for dryness? | Yes No | Brand? Frequency? | |

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The following information is requested in compliance with the HITECH Act:

Race: _____Preferred language: _____

Ethnicity:_____Preferred method of communication? Phone Mail Email Text

Patient Health History Today's Date: _____

Family Practice: _____Location: _____Doctor: _____

Doctor Phone Number: _____ Date of last Physical/Exam: _____

Please list all of your current medications (include over the counter, vitamins, and herbal therapy):

_____

Medication allergies:_____

Non-medication allergies:_____

List all major surgeries and/or eye surgeries: _____

Are you pregnant? Yes No Are you nursing? Yes No

Please indicate if any of the conditions apply to you or a family member (blood relative, not spouse)

| Disease/Condition | Yourself | Family Member | Maternal or Paternal |
|---|---|---|---|
| Eye turn (lazy, crossed, etc) | Yes No | Yes No | |
| Glaucoma | Yes No | Yes No | |
| Macular Degeneration | Yes No | Yes No | |
| Retinal Detachment | Yes No | Yes No | |
| Blindness | Yes No | Yes No | |
| Diabetes | Yes (years____) No | Yes No | |
| If yes… | Type 1 or Type 2 | | |
| | ○ Insulin<br>○ oral medication<br>○ diet controlled | Last fasting blood sugar _____<br>Last A1C _____ | |

Review of systems Please indicate if you have or ever have had problems with the following conditions:

| | | | | |
|---|---|---|---|---|
| Cardiovascular<br>○ High blood pressure<br>○ Cardiovascular disease<br>○ Elevated cholesterol<br>○ Stroke<br>○ _____ | Constitutional<br>○ Weight loss<br>○ Weight gain<br>○ Fatigue<br>○ Trauma<br>○ _____ | Endocrine/Glands<br>○ Diabetes<br>○ Hormone dysfunction<br>○ Thyroid High/Low<br>○ Grave's disease<br>○ Hashimoto's<br>○ _____ | Gastrointestinal<br>○ Inflammatory bowel<br>○ Colitis<br>○ Acid reflux/ulcer<br>○ Crohn's Disease<br>○ _____ | Genital/Urinary<br>○ UT infections<br>○ Herpes<br>○ Prostate disorder<br>○ Kidney disease<br>○ _____ |
| Ear, Nose, & Throat<br>○ Sinusitis<br>○ Hearing loss<br>○ Headaches<br>○ Dry mouth<br>○ _____ | Hematologic/Lymphatic<br>○ Anemia<br>○ Leukemia<br>○ Bleeding disorder<br>○ Cancer<br>○ _____ | Immunologic<br>○ Shingles<br>○ HIV positive<br>○ Sjogren's syndrome<br>○ Autoimmune<br>○ _____ | Skin/Integumentary<br>○ Eczema<br>○ Rosacea<br>○ Psoriasis<br>○ _____ | Muscle/Skeletal<br>○ Arthritis<br>○ Fibromyalgia<br>○ Rheumatoid Arthritis<br>○ _____ |
| Neurological<br>○ Multiple Sclerosis<br>○ Epilepsy<br>○ Tremors<br>○ Migraines<br>○ _____ | Psychiatric<br>○ Depression<br>○ Bi-polar<br>○ ADD/ADHD<br>○ Autism Spectrum<br>○ _____ | Respiratory<br>○ Asthma<br>○ Bronchitis<br>○ COPD<br>○ _____ | Social<br>○ Current smoker<br>○ Years smoking _____<br>○ How many per day?_____<br>○ Smokeless tobacco user<br>○ Former smoker<br>○ Years smoke free _____<br>○ Never smoked | |

# of alcoholic beverages consumed per day/week/month/year (circle one) is _____

5/30/2022 Please sign below to acknowledge that this information is correct or has been reviewed and updated

Signature (Responsible party): _____Date: _____