



**NEW PATIENT INFORMATION**

Patient Name				Date of Birth	
Address					
City		State		Zip	
Home Phone				Cell Phone	
Work Phone				Email	
Gender				Preferred Language	
Primary Physician				Physician Phone #	
Guarantor Name				Guarantor Phone #	

**VISION INSURANCE INFORMATION**

Insurance Co.		Insurance Phone	
Insurance ID#		Group #	
Insured's Name			
Insured's D.O.B.		Relationship	(check one) Self ___ Spouse ___ Child ___ Other ___

Vision Plans cover "well vision" exams. Any medical history or diagnosis will result in the visit being billed to your medical insurance.

**PRIMARY MEDICAL INSURANCE INFORMATION**

Insurance Co.		Insurance Phone	
Insurance ID#		Group #	
Insured's Name			
Insured's D.O.B.		Relationship	Self ___ Spouse ___ Child ___ Other ___

**SECONDARY MEDICAL INSURANCE INFORMATION**

Insurance Co.		Insurance Phone	
Insurance ID#		Group # Insured's	
Insured's Name			
Insured's D.O.B.		Relationship to Patient	Self ___ Spouse ___ Child ___ Other ___

**List of medications you currently take and for what condition:**

- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_
- Medication: \_\_\_\_\_ used for : \_\_\_\_\_

Date of last eye exam : \_\_\_\_\_

Eye injuries and surgeries with dates: \_\_\_\_\_

Drug Allergies or other Allergens: \_\_\_\_\_

**PERSONAL HEALTH HISTORY (check if yes)**

**Eyes (current symptoms & history)**

- none
- dry eyes
- eye pain
- eyelid swelling
- floaters
- flashes
- itching eyes
- light sensitivity
- cataract
- glaucoma
- macular degeneration
- surgery
- other \_\_\_\_\_
- eye drops or eye medications \_\_\_\_\_

**Allergic/Immunologic**

- none
- drug allergy
- hay fever/seasonal
- rheumatoid arthritis
- lupus
- other \_\_\_\_\_

**Cardiovascular**

- none
- heart disease
- hypertension
- stroke
- other \_\_\_\_\_

**Constitutional**

- none
- fatigue
- weight loss/gain
- other \_\_\_\_\_

**Ears, Nose, Throat**

- none
- hearing problems
- sinus problems

**Ears, Nose, Throat (cont.)**

- TMJ disorder
- upper resp. infection
- other \_\_\_\_\_

**Endocrine**

- none
- diabetes
- high/low blood sugar
- thyroid dysfunction
- hormonal dysfunction
- other \_\_\_\_\_

**Gastrointestinal**

- none
- colitis
- crohn's
- ulcer
- other \_\_\_\_\_

**Genitourinary**

- none
- kidney problems
- renal failure
- dialysis
- sexually transmitted disease
- other \_\_\_\_\_

**Hematologic/Lymphatic**

- none
- anemia
- leukemia
- cancer
- HIV
- other \_\_\_\_\_

**Musculoskeletal**

- none
- fibromyalgia
- muscular dystrophy
- osteoarthritis
- other \_\_\_\_\_

**Pregnant  yes  no**

**Neurological**

- none
- multiple sclerosis
- epilepsy
- migraines
- other \_\_\_\_\_

**Psychiatric**

- none
- depression
- bipolar
- other \_\_\_\_\_

**Respiratory**

- none
- cigarette smoker
- asthma
- bronchitis
- emphysema
- other \_\_\_\_\_

**Skin/Integumentary**

- none
- eczema
- rosacea
- psoriasis
- other \_\_\_\_\_

**Alcohol use**

- yes \_\_\_\_\_
- no

**Tobacco use**

- yes \_\_\_\_\_
- no

**Marijuana use**

- yes \_\_\_\_\_
- no

**FAMILY HEALTH HISTORY (check if yes, please indicate relationship to patient, i.e. Mother, Father, Grandparents, Siblings)**

- cancer - \_\_\_\_\_
- diabetes \_\_\_\_\_
- heart disease - \_\_\_\_\_
- high blood pressure - \_\_\_\_\_
- stroke - \_\_\_\_\_
- glaucoma - \_\_\_\_\_
- cataracts- \_\_\_\_\_
- macular degeneration- \_\_\_\_\_
- other - \_\_\_\_\_