EXISTING PATIENT FORM

GENERAL INFORMATION

Patient First, MI, Last Name, Preferred Name _____ Birth Sex: Male | Female

Street Address _____ **[ ] No Address Changes**

City, State, Zip _____ Date of Birth _____

Cell Phone _____ Email _____

Preferred Contact Method: Cell Phone | Text | Email | Emergency Contact Person and Phone _____

INSURANCE INFORMATION

[ ] No Insurance Changes

Vision Insurance _____ Primary Member Name _____

Member ID # _____ Member Date of Birth _____

Medical Insurance _____ Primary Member Name _____

Insurance ID # _____ Insurance Policy # / Group ID # _____

Primary Member Date of Birth _____ Primary Member Employer _____

EYE HISTORY

Reason for Today's Visit:

- ❒ Comprehensive Eye Exam
- ❒ Contact Lens Exam (including Comprehensive)
- ❒ Medical Office Visit

Primary Complaint: _____

_____

_____

Date of Last Eye Exam _____

Currently Wear Glasses? _____ Yes No

Currently Wear Contacts? _____ Yes No

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts _____ Self No Family

Glaucoma _____ Self No Family

LASIK or PRK _____ Self No Family

Lazy Eye / Eye Turn _____ Self No Family

Macular Degeneration _____ Self No Family

Retinal Detachment _____ Self No Family

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ❒ Blurry Vision _____ Distance | Near
- ❒ Eye Strain _____
- ❒ Redness _____
- ❒ Dryness _____
- ❒ Sandy or Gritty Feeling _____
- ❒ Burning _____
- ❒ Itching _____
- ❒ Discharge _____
- ❒ Excess Tearing or Watering _____
- ❒ Eye Pain or Soreness _____
- ❒ Double Vision _____
- ❒ Floaters or Spots _____
- ❒ Halos _____
- ❒ Headaches _____
- ❒ Light Flashes _____
- ❒ Light Sensitivity _____

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV _____ Self No Family

Allergies _____ Self No Family

Arthritis _____ Self No Family

Asthma _____ Self No Family

Autoimmune _____ Self No Family

Cancer _____ Self No Family

Diabetes _____ Self No Family

Ears, Nose, Throat Conditions _____ Self No Family

Gastrointestinal Conditions _____ Self No Family

Heart Disease _____ Self No Family

High Blood Pressure _____ Self No Family

High Cholesterol _____ Self No Family

Kidney Disease _____ Self No Family

Lupus _____ Self No Family

Neurological Conditions _____ Self No Family

Psychiatric Disorder _____ Self No Family

Seizures _____ Self No Family

Skin Conditions _____ Self No Family

Stroke _____ Self No Family

Thyroid Dysfunction _____ Self No Family

Vascular _____ Self No Family

Current Medications (prescription and over-the-counter) _____

_____

_____

_____

Medication Allergies _____

_____

Import Medication Consent: _____

SOCIAL HISTORY

Are you pregnant or nursing? _____ Yes No

Do you currently drive? _____ Yes No

Do you drink alcohol? _____ Yes No

Have you ever smoked? _____ Yes No

Do you currently smoke? _____ Yes No

For Office Use Only

Current Glasses:

OD: _____

OS: _____

Contact Lenses: Brand, Power, BC, Diam.

OD: _____

OS: _____

IOPs: OD: _____ mmHg OS: _____ mmHg **Temp:**_____ **[ ] Retinal Photos** **[ ] F/U:** _____