

Patient Information and History

Patient's Full Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email Address _____

Occupation _____ Employer(Parent's for children) _____

Primary Insured _____ SS/ID# _____ DOB _____

Primary Insured's Employer _____

If Student, Grade Level and School _____

If Minor, Parent's Name(s) _____

Other Family Members at home _____

Referred to our Office by _____

Payment Cash/Check Charge VSP Eye Med Other _____

Please Note: If you are a contact lens wearer, your needs for visual care are more complex than those of the patient who chooses to wear glasses only. If you are a contact lens wearer, you will be receiving additional testing and evaluation you need during your visit with us. This may or may not be fully covered by your vision plan. Please ask our staff if you have any questions about contact lenses or your vision coverage.

Reason for your visit? _____

Last exam? _____ Where? At this office _____

Do you use glasses? yes no Do you use contacts? yes no

Have you participated in Vision Therapy? _____ If so, where and when? _____

I acknowledge that I received a copy of Family Optometry P.C.'s Notice of Privacy Rights.

Signature _____ Date _____

How is your health in general? _____ Who is your doctor? _____

Recent medical treatments? _____

Medications? _____

Allergies to medicines? _____

Other Allergies? _____

Do you use tobacco products? _____ Drugs? _____ Alcohol? _____

If so what, when, and how much? _____

Have you or your family had problems with: Please Circle (S) for yourself and (F) for your family.

Heart Disease?	S	F	Learning?	S	F
Diabetes?	S	F	Glaucoma?	S	F
High Blood Pressure?	S	F	Eye Disease?	S	F
High Cholesterol?	S	F	Eye Surgery?	S	F
Ears, Nose, Throat?	S	F	Dyslexia ?	S	F
Lungs/ Breathing?	S	F	A Turned Eye?	S	F
Skin?	S	F	A "Lazy" Eye?	S	F
Glands?	S	F	Color Vision?	S	F
Muscles/ bones/ nerves ?	S	F	Blindness?	S	F
Neurological or Mental Health?	S	F	Eye Injury?	S	F

Please Check if Ever True

<input type="checkbox"/> Blurry Vision @ Distance	<input type="checkbox"/> Sudden Vision Loss
<input type="checkbox"/> Blurry Vision @ Near	<input type="checkbox"/> Spots or Floaters
<input type="checkbox"/> Seeing Double	<input type="checkbox"/> Flashes of light, sparks or stars
<input type="checkbox"/> Avoids Close Work	<input type="checkbox"/> Problems seeing at night
<input type="checkbox"/> Short Attention Span For Visual Tasks	<input type="checkbox"/> Colored Halos around lights
<input type="checkbox"/> Hard to remember what is read	<input type="checkbox"/> Excessive blinking or rubbing of eyes
<input type="checkbox"/> Skipping, Words, Phrases or Lines of Print	<input type="checkbox"/> Squints frowns or scowls
<input type="checkbox"/> Reversal of Words, Letters, or Numbers	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Losing place when reading or writing	<input type="checkbox"/> Motion Sickness
<input type="checkbox"/> Spelling Problems	<input type="checkbox"/> Headaches When? _____
<input type="checkbox"/> Using a finger or marker to keep place	_____
<input type="checkbox"/> Closer than normal reading distance	Eyes that <input type="checkbox"/> are Dry or <input type="checkbox"/> Sandy
<input type="checkbox"/> Farther than normal reading distance	Eyes that <input type="checkbox"/> are Red or <input type="checkbox"/> Gritty
<input type="checkbox"/> Print blurs after a short time	Eyes that <input type="checkbox"/> Hurt or <input type="checkbox"/> Burn
<input type="checkbox"/> Words seem to float around	Eyes that <input type="checkbox"/> Itch or <input type="checkbox"/> Water