EYECARE GALLERIA OPTOMETRY

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Welcome To Our Office

Today's Date ____________
Last ____________ First ____________ MI ____
Street ____________
City ____________ State ____ Zip Code ____________
Home Phone ____________
Work Phone ____________
Patient's Social Security Number: ____________
Employer (or School): ____________
Occupation (or Grade): ____________
Spouse (or Parent's Name): ____________
Spouse (or Parent's Work): ____________
Date of Birth ____________ Age ______ Sex M F
Email Address ____________
What is the major purpose of this visit?
____
Any problems with your present contact lenses or glasses?
____

VERY IMPORTANT! **NEW PATIENTS ONLY:**
Who may we thank for referring you to our office?
Name of friend or relative ____________
If not referred, how did you choose our office for your needs?

❑ Another Dr. ❑ Insurance List
❑ Sign/Building ❑ Newspaper/Radio/TV
❑ Yellow Pages. Which directory? ____________
❑ Web Page. Which Web site? ____________
❑ Other ____________

Insurance Information

Vision Insurance: ____________
Subscriber Name: ____________
Subscriber Social Security Number: ____________
Subscriber Birth date: ____________

Primary Medical Insurance: ____________
Subscriber Name: ____________
Subscriber Social Security Number: ____________
Subscriber Birth date: ____________

Do you participate in a flex spending account? ❑ Yes ❑ No
How will you settle your account today?
❑ Check ❑ Cash ❑ Credit Card

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

		Relationship
Blindness	❑	____________
Cataracts	❑	____________
Corneal Problems	❑	____________
Glaucoma	❑	____________
Lazy Eye	❑	____________
Macular Degeneration	❑	____________
Retinal Problems	❑	____________
Diabetes	❑	____________
Heart Disease	❑	____________

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ____________
Town ____________
Date of Last Physical Check-up ____________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins & birth control pills) ____________
____
____
Allergies to Medications: ❑ Yes ❑ No
____

Have you ever been diagnosed or treated for the following?

❑ Allergies ❑ Diabetes ❑ Thyroid
❑ Asthma ❑ Heart Disease ❑ Other ____________
❑ Arthritis ❑ High Blood Pressure ____________
❑ Cancer ❑ Kidney
❑ Cholesterol ❑ Nerves

Patient Eye History

Date of Last Eye Exam ____________
By Whom? ____________
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind? ____________
Solutions Used ____________
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? ____________
Have you ever tried contact lenses? ❑ Yes ❑ No

Do you . . . (Check box if your answer is yes)
❑ . . Work at a computer?
❑ . . Think you might benefit from thinner, lighter lenses?
❑ . . Have interest in a "Test Drive" of the latest in contact lens design?
❑ . . Spend time outdoors? (How much?) ________ hrs/wk
❑ . . Have prescription sunglasses?
❑ . . Prefer not to wear your glasses at times?
❑ . . Want information on Laser Vision Correction surgery?
❑ . . Have interest in a non-surgical approach to vision correction?
❑ . . Have more than 1 pair of current Rx glasses?
❑ . . Have children?
❑ . . Have family members in need of eyecare?

If you wear bifocals, are you bothered by the lines or head tilting?
❑ Yes ❑ No
If you wear contact lenses, are you satisfied with the vision and comfort
❑ Yes ❑ No

Have you ever been diagnosed or treated for the following?

❑ Cataracts ❑ Iritis/Uveitis
❑ Corneal Abrasion ❑ Lazy Eye
❑ Eye infection ❑ Macular Degeneration
❑ Eye injury ❑ Retinal Detachment
❑ Glaucoma ❑ Other eye disorders

Do you experience or have you ever experienced?

❑ Blurry vision ❑ Flash of light ❑ Sunlight sensitivity
❑ Burning ❑ Floaters/spots ❑ Tearing
❑ Cross eye/eye turn ❑ Grittiness ❑ Trouble seeing at nig
❑ Double vision ❑ Headaches ❑ Uncomfortable glas
❑ Occasional Dryness ❑ Itchiness