Established Patient History

Patient First Name:___________________________ Last Name_____________________________ Date:___________________

Reason for TODAY'S Visit	
Routine Eye Exam Yes / No Eye Irritation Yes / No	Do you work on a computer? Yes / No
Need/Want Glasses Yes / No Sunglasses Yes / No	How many hours per day? _______________
Need/Want Contacts Yes / No Have you worn them previously Yes / No	Do you have sunglasses? Yes / No
Lasik-Laser Vision Correction Evaluation Yes / No Need more info? Yes / No	Sports/Hobbies _____________________________
Are there any issues or concerns that you would like to address with the Doctor today:	Do you have specific visual needs that need to be addressed? Yes / No
____	Explain_____________________________________

PHYSICAL HISTORY

Date of Last **PHYSICAL EXAM** ____________________ Doctor____________________________ Town_____________________________

Specialty Physician _____________________________ Specialty __________________________Town ___________________________

Specialty Physician _____________________________ Specialty __________________________Town ___________________________

We like to communicate exam results to your Primary and Specialty physicians.

Who should we send a report to? ____

Are you diabetic/pre-diabetic? Yes / No Last A1c _________________ Date of last Blood work? _______________________

Last Home testing _______________ What was the reading __________________

Do you have High Blood Pressure? Yes / No Are you a smoker yes / No

Have you been diagnosed, or are you being treated for any new medical condition that you did not have during your last visit? Yes / NO

If so, what condition (s)?____

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Do you have any allergies? Yes / No If so, to what?____

Women: Are you pregnant? Yes / No How many weeks?________________________ Are you Nursing Yes / No

Do you experience dry, irritated or itchy eyes? Yes / No Are you using artificial tear drops Yes / No How many times a day _______

Many systemic medications affect your vision and the health of your eyes. Please list your medications below or allow us to copy your list.

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PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. A $20 (TWENTY DOLLAR) BILLING CHARGE WILL BE APPLIED TO ALL OUTSTANDING BALANCES, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. THE RETURNED CHECK FEE IS $30 (THIRTY DOLLARS). PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTIONS OF LEGAL ACTIONS. THERE WILL BE A $30 "NO-SHOW" CHARGE FOR NOT KEEPING APPOINTMENTS UNLESS WE HAVE BEEN NOTIFIED 24 HOURS IN ADVANCE.

This information is confidential and was given by: ____ **Date** ______________