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 night
❑ Double vision	❑ Headaches	❑ Uncomfortable glasses
❑ Occasional Dryness	❑ Itchiness	