WELCOME TO OUR OFFICE: Thank you for the opportunity to provide for your visual needs. In order to serve you better, please complete the following questionnaire.

Date: _____/_____/____

Name: __________________________ _____ ________________________________ Mr. Mrs. Miss Ms. Dr.

First M.I. Last

Address: ____ City: _________________________ Zip: __________

Home Phone: (____)________________ Day/Work Phone: (____)________________ Cell: (____)_________________

Age: _____ Date of Birth: _____/_____/_____ Email address: ______________________________________

Vision Plan: ___________________________ Member Name/Primary Holder: __________________________

Social Security#/Member ID#: ___________________________

Medical Insurance: _______________________ Employer: ____________________________

Primary Care Physician (Name and Location): ___________________________ ___________________________

If Student: School: ___________________ Grade: _________ If Minor: Parent/Guardian: _________________

Whom may we thank for referring you to our office? __________________________

If your appointment is for an eye examination, please answer the following questions:

Do you or any member of your immediate family (parents or siblings) have any of the following:

	Yourself		Family Members	
• High Blood Pressure	Yes / No	Year diagnosed: _______	Yes / No	If so, who: __________
• Diabetes	Yes / No	Year diagnosed: _______	Yes / No	If so, who: __________
• High Cholesterol	Yes / No	Year diagnosed: _______	Yes / No	If so, who: __________
• Eye Diseases	Yes / No	If so, what: ______________	Yes / No	If so, who: __________
• Eye Surgeries	Yes / No	If so, for what condition: ____________________		

Are you presently taking any medications? Yes / No

If yes, please list:____

Are you allergic to any medications? Yes / No

If yes, please list:____

Do you have any other allergies? Yes / No

If yes, please list: ____

Smoking History: Never smoker Former smoker Current smoker: Light Heavy

Do you currently wear eye glasses? Yes / No

Do you currently wear contact lenses? Yes / No If yes, brand/type: _________________________________

If no, have you ever worn contact lenses? Yes / No Are you interested in trying contact lenses? Yes / No

Occupation: ____________________________ Hobbies: ____________________________

Is there any other information about your eyes, general health, or special vision needs that we need to know about?

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THANK YOU AGAIN FOR SELECTING OUR OFFICE FOR YOUR VISION CARE.