Welcome Back to Our Office

Today's Date:_____

Name:_____

Date of Birth:_____ Age:_____

Address:_____

City: _____ State: ____ Zip: _____

Phone Numbers:_____

E-mail:_____

Main Reason for Visit

You are here today for:

[ ] Glasses

[ ] Contact Lenses

[ ] Having problem with_____

Since your last visit are there any changes in your health or medications?

[ ] No

[ ] Yes Please explain_____

_____

Personal & Family Medical History

Please circle if you or someone in your family has

Allergies	Self	Family	Glaucoma	Self	Family
Asthma	Self	Family	Eye diseases	Self	Family
Arthritis	Self	Family	Heart diseases	Self	Family
Cancer	Self	Family	Eye injury	Self	Family
Eye surgery	Self	Family	High blood pressure	Self	Family
Cataracts	Self	Family	Diabetes	Self	Family
Thyroid	Self	Family	Type 1 or 2	Self	Family

Cigarettes	No	Yes
Tobacco	No	Yes
Alcohol	No	Yes
Pregnant or Breast Feeding	No	Yes

Other substances _____

Current Medications (Rx & Over-the-Counter)

Name of Medication

Antihistamines	No	Yes	_____
Diuretics	No	Yes	_____
Blood Pressure Pills	No	Yes	_____
Oral contraceptives	No	Yes	_____
Diabetes Med	No	Yes	_____
Eye drops	No	Yes	_____
Other	No	Yes	_____

Are you currently under the care of a physician? No Yes

Name of physician_____

Full payment is due before any materials can be ordered or released.

Method of payment:

❑ Check ❑ Cash ❑ Visa ❑ MasterCard

❑ Discover [ ] Flex Spending Account

_____ _____

SIGNED **DATE**

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