Precision Optometry™

WELCOME TO OUR OFFICE

PATIENT DEMOGRAPHICS

Last _____

First _____ MI _____

Street _____

City _____ State ____ Zip _____

Home Phone _____

Cell Phone _____

Patient's SSN _____ - _____ - _____

Employer (or School) _____

Occupation (or Grade) _____

Date of Birth ____/____/____ Age _____

Gender Male Female

Email _____

INSURANCE:

Vision Insurance _____

Subscriber's Name _____

Subscriber's SSN _____ - _____ - _____

Subscriber's DOB _____

Primary Medical Insurance _____

Subscriber's Name _____

Subscriber's SSN _____ - _____ - _____

Subscriber's DOB _____

Would you like a Staff member to review your insurance benefits with you prior to your exam?

YES NO

Will you be using a flex spending account or health savings account?

YES NO

PERSONAL AND FAMILY EYE HISTORY

Date of Last Eye Exam ____/____/____

GLASSES:

Have you been prescribed eye glasses?

YES NO

Are you satified with your current eyeglasses?

YES NO

CONTACT LENSES:

Have you ever tried contact lenses?

YES NO

Do your currently wear contact lenses?

If YES, What kind? _____

Solution used: _____

Are you satisfied with the vision of your contact lenses?

YES NO

Are you satisfied with the comfort of your contact lenses?

YES NO

FAMILY MEDICAL HISTORY

Is there are family medical history of any of the follow medical conditions?

PLEASE CHECK BOX AND LIST FAMILY MEMBER:

Blindness	☐	_____
Cataracts	☐	_____
Corneal Problems	☐	_____
Diabetes	☐	_____
Glaucoma	☐	_____
Heart Disease	☐	_____
Lazy Eye	☐	_____
Macular Degeneration	☐	_____
Retinal Detachment	☐	_____

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PATIENT HEALTH HISTORY

Have you ever experienced, been diagnosed or treated for any of the following:
Check the boxes that apply:

- ☐ Blurry Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Eye infection
- ☐ Floaters/Spots
- ☐ Glaucoma
- ☐ Pterygium
- ☐ Itchy Eyes
- ☐ Tearing Eyes
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Burning Eyes
- ☐ Corneal Abrasions
- ☐ Nystagmus
- ☐ Eye Injury
- ☐ Lazy Eye
- ☐ Iritis/Uveitis
- ☐ Crossed eye/Eye Turn
- ☐ Migraine
- ☐ Sunlight Sensitivity
- ☐ Trouble seeing at night
- ☐ Other

Lifestyle: *Do You...*

- ☐ work at the computer? _____ Hrs/Days
- ☐ think you might benefit from glare reduction?
- ☐ have interest to "test drive" the latest contact lenses?
- ☐ spend time outdoors? _____ Hrs/Days
- ☐ have prescription sunwear?
- ☐ prefer not to wear glasses at time?
- ☐ want information for Laser Vision Correction surgery?
- ☐ have more that 1 pair of current RX eyewear?
- ☐ have children
- ☐ have family members in need of eyecare?

Medical Health History:

Primary Care Physician: _____

Phone number: _____

Last Physical Check-up: ____/____/____

CURRENT MEDICATIONS (RX or over the counter)

(List medications including eye drops, vitamins, birth control pills)

_____

_____

_____

_____

_____

Allergies to medications? ☐ YES ☐ NO

If yes, please list: _____

_____

Are you currently pregnant: ☐ YES ☐ NO

Have you had any surgeries: ☐ YES ☐ NO

If yes, please list: _____

_____

Have you ever been diagnosed or treated for the following health problems?

	YES	NO
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Endocrine	☐	☐
Fatigue	☐	☐
Ears/Nose/Throat	☐	☐
Asthma/Respiratory	☐	☐
Stroke	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Skin Disorders	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological/Seizures	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Heart Disease	☐	☐
Thyroid	☐	☐
Sleep Apnea	☐	☐

Others _____

All the above information I have provided is correct to the best of my knowledge.

Signature _____ Date _____