Optometric Expressions

Patient Information Record

DATE _____

NAME _____
(LAST) (FIRST) (MIDDLE)

ADDRESS _____

CITY, STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

BIRTHDATE _____ ARE YOU A FORMER PATIENT? YES / NO

EMPLOYER _____

OCCUPATION _____

DR. LIC. NO. _____ S.S.N. _____

HAS YOUR NAME CHANGED SINCE YOUR LAST EXAM? YES / NO

FORMER NAME _____

IF PATIENT IS DEPENDENT, NAME OF PERSON RESPONSIBLE FOR ACCOUNT:

_____

ADDRESS _____

CITY, STATE _____ ZIP _____

PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PAYMENT TO BE MADE BY: _____CASH _____CHECK _____CREDIT CARD

(It is customary to pay for services when rendered)

INSURANCE CO. _____

(We do not accept assignment of insurance benefits. We will be happy to process your forms, but the bill must be paid at delivery)

Case History

1. DATE OF LAST EXAM _____ DILATED? _____
2. REASON FOR THIS EXAM: _____ NOT SEEING WELL. _____ HEADACHE. _____EYE STRAIN. _____OTHER - _____
3. ARE YOU INTERESTED IN: _____ GLASSES _____ CONTACTS
   HAVE YOU EVER WORN: _____ GLASSES _____ CONTACTS
4. LIST ANY HOBBIES THAT REQUIRE SPECIFIC VISUAL REQUIREMENTS:

   _____
5. HOW OFTEN DO YOU USE A COMPUTER: _____
6. HAVE YOU EVER HAD DIFFICULTY ADJUSTING TO
   PRESCRIPTION CHANGES: _____ YES _____ NO

MEDICAL HISTORY

I. HAVE YOU EVER HAD AN EYE INJURY, EYE INFECTION,
EYE DISEASE, OR EYE OPERATION? NO_____ YES_____ EXPLAIN_____

_____

2. DO YOU HAVE A FAMILY HISTORY OF:

(CIRCLE YES OR NO)		(FAMILY MEMBER)
YES	NO	DIABETES _____
YES	NO	HIGH BLOOD PRESSURE _____
YES	NO	CATARACTS _____
YES	NO	GLAUCOMA _____
YES	NO	MACULAR DEGENERATION _____
YES	NO	RETINAL DETACHMENT _____
YES	NO	ALLERGIES _____
YES	NO	MEDICATION ALLERGIES _____
YES	NO	OTHER _____

3. HOW IS YOUR PRESENT HEALTH? _____ GOOD _____FAIR _____ POOR
4. ARE YOU TAKING ANY PRESCRIPTION DRUGS? _____YES _____ NO
   NAME OF DRUGS: _____
5. DO YOU USE: CIGARETTES/TOBACCO? _____YES _____NO
   ALCOHOL? _____YES _____NO