Optical Academy

PATIENT INFORMATION

D.O.B: / /

LAST NAME FIRST NAME

SEX: M ☐ F ☐

ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

EMPLOYER OCCUPATION

REFERRED BY EMAIL SIGNATURE

WOULD YOU LIKE A CONTACT LENS EXAM AND FITTING? YES ☐ NO ☐ PLEASE ADD $60 ☐

PLAN NAME GROUP

INSURANCE NAME RELATIONSHIP TO PATIENT: SELF ☐ SPOUSE ☐ CHILD ☐

INSURED ID# REFERRED BY REFERRED BY

WHAT IS THE REASON FOR TODAY'S EXAM?

☐ AGE OF PRESENT SUNGLASSES ☐ AGE OF PRESENT GLASSES _____ DATE OF LAST EYE EXAM _____ FROM DR. PREVIOUS PATIENT? ☐ YES ☐ NO

DO YOU OR ANY OF YOUR RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTERS) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVES	NONE
DIABETES	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐
THYROID PROBLEMS	☐	☐	☐
HEART DISEASE	☐	☐	☐
ASTHMA	☐	☐	☐
CANCER	☐	☐	☐

	SELF	RELATIVES	NONE
GLAUCOMA	☐	☐	☐
CATARACTS	☐	☐	☐
RETINAL DISEASE	☐	☐	☐
EYE SURGERY	☐	☐	☐
EYE INJURY	☐	☐	☐
OTHER	☐	☐	☐

	YES	NO	
DO YOU SEE DOUBLE	☐	☐	
FREQUENT HEADACHES	☐	☐	
ARE YOU PREGNANT	☐	☐	____
EYES BEEN DILATED	☐	☐	YEAR

PRIMARY CARE DR. _____

PLEASE EXPLAIN ANY POSITIVE FINDINGS

ARE YOU TAKING ANY PRESCRIPTION OR OVER THE COUNTER EYE DROPS?

ARE YOU TAKING ANY OTHER MEDICATION?