



PATIENT HISTORY FORM

Patient's First Name: M.I.: Last Name: DOB: Today's Date:
Address: City: State: Zip:
Home Phone: Work Phone: Cell:
E-Mail:
Employer: Occupation:

FOR OFFICE USE ONLY

INSURANCE

Vision Insurance: Member ID:
Primary Insured Name: Insured's DOB:
Primary Insured Social Security #:
Medical Insurance: Member ID:
Primary Place of Employment:
How were you referred to our clinic? Friend/Relative Sign Insurance Other

VISUAL AND MEDICAL HISTORY

Reason for today's visit?
Date of last eye exam? By whom?
Do you presently wear? (Circle) GLASSES / CONTACTS / BOTH
If not wearing any contacts, are you interested in trying them today? YES / NO
If you wear contact lenses, do you know what type or brand?

Please circle any condition that applies to you: Do you currently have any problems in the following areas?
Double Vision YES / NO Diabetes YES / NO
Eye Pain YES / NO High Blood Pressure YES / NO
Itching YES / NO Heart Problems YES / NO
Dry Eyes YES / NO Respiratory Problems YES / NO
Tearing YES / NO Glaucoma YES / NO
Floaters YES / NO Ears, Nose, Throat YES / NO
Burning YES / NO Thyroid YES / NO
Redness YES / NO Arthritis YES / NO

Are you currently taking any medications? YES / NO Please list
Do you have allergies to any medications? YES / NO Please list

I have read and understand the Health Information Patient Privacy Act (HIPPA).
Signature Date