Advanced Eyecare & Optical
Dr. Brenta Medley, Optometrist
Dr. Patricia Koester, Optometrist

Welcome to Our Office ☺ **Today's Date** ___/___/___
(Please Print)

Name ______________________________ MI_____ Occupation____________________

Name of Parent / Guardian (if Patient is a Minor) ______________________________

Address ______________________________ City____________ State______ Zip Code__________

Home Phone (____) ____________ Work Phone (____) ____________ Cell Phone (____) ____________

Birth Date____/____/____ Last Eye Exam____/____/____ Last Medical Exam____/____/____

S.S. Number__________________ Vision Insurance __________________ Insurance ID #______________

E-mail Address__________________ Who may we thank for your referral? ____________________

Medical History
Do you have any allergies to medications? ☐ Yes ☐ No If yes, please list: ____________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): ______________________________

List all major injuries, surgeries, and/or hospitalizations you have had: ______________________

Are you pregnant and/or nursing? ☐ Yes ☐ No

Circle any of the following that you have had:

Crossed eyes	Prominent eyes	Cataracts
Lazy eye	Glaucoma	Eye infections or eye injury
Drooping eyelid	Retinal disease	Other: ____________

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ______________
Do you wear contacts? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ______________
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Family History
Please note any family history (parents, grandparents, siblings, and/or children, living or deceased) for the following medical conditions:

	Family Member		Family Member
Blindness	____________	Cancer	____________
Cataract	____________	Diabetes	____________
Crossed Eyes	____________	Heart Disease	____________
Glaucoma	____________	Hypertension	____________
Macular Degeneration	____________	Kidney Disease	____________
Retinal Detachment	____________	Lupus	____________
Retinal Disease	____________	Thyroid Disease	____________
Other	____________	Arthritis	____________

Social History
Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
If yes, please describe: ______________________________
Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: ____________________
Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: ____________________
Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: ____________________
Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis

Review of Systems

Do you currently (or have you ever had) any problems in the following areas: (If YES, please explain and list medications).

SYSTEM	NO	YES	?	EXPLAIN/MEDICATIONS
INTEGUMENTARY (skin)	☐	☐	☐	
NEUROLOGIC				
Headaches/Migraines	☐	☐	☐	
Seizures	☐	☐	☐	
EYES				
Loss/Blurred Vision	☐	☐	☐	
Loss Side Vision	☐	☐	☐	
Double Vision	☐	☐	☐	
Dryness/Redness	☐	☐	☐	
Mucous Discharge	☐	☐	☐	
Sandy or Gritty Feeling	☐	☐	☐	
Itching/Burning/Tired Eyes	☐	☐	☐	
Foreign Body Sensation	☐	☐	☐	
Excess Tearing/Watering	☐	☐	☐	
Glare/Light Sensitivity	☐	☐	☐	
Eye Pain or Soreness	☐	☐	☐	
Sties or Chalazion	☐	☐	☐	
Flashes/Floaters in Vision	☐	☐	☐	
EARS, NOSE, MOUTH, THROAT				
Allergies	☐	☐	☐	
Sinus Congestion	☐	☐	☐	
Runny Nose	☐	☐	☐	
Chronic Cough	☐	☐	☐	
RESPIRATORY				
Asthma/Bronchitis	☐	☐	☐	
Emphysema	☐	☐	☐	
VASCULAR				
Diabetes	☐	☐	☐	
Heart Pain	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Vascular Disease	☐	☐	☐	
GASTROINTESTINAL				
Diarrhea/Constipation	☐	☐	☐	
GENITOURINARY (genitals/kidney/bladder)	☐	☐	☐	
BONES/JOINT/MUSCLES				
Arthritis/Joint Pain	☐	☐	☐	
Muscle Pain	☐	☐	☐	
LYMPHATIC/HEMATOLOGIC				
Anemia	☐	☐	☐	
Bleeding Problems	☐	☐	☐	
ENDOCRINE (thyroid/other glands)	☐	☐	☐	
PSYCHIATRIC	☐	☐	☐	

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor/s/to examine, diagnose and initiate treatment as deemed appropriate. I further, attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

Payment Policy:

1. Examination fee is due at time of exam.
2. Balance of account is due at dispensing.
3. A $25.00 charge will be assessed for all returned checks.

______________________________ ______________________________

Patient/Parent or Guardian Today's Date