Welcome to Our Office
Advanced Eye Care & Optical
PATIENT INFORMATION
Please Complete **ALL** Questions, Check & Sign

Please Print Appointment Date _____

Name_____ (Nickname)_____ S.S.# _____
First M.I. Last

Street Address _____ City _____ State _____ Zip _____

Cell Phone # _____ May We Text You? Y or N Alternate # _____ (Home or Work)

Date of Birth ___/___/___ Age _____ Sex ____ Marital Status [ ] S [ ] M [ ] D [ ] W Email _____

Employer _____ Occupation _____ Vision Ins. _____ I.D# _____

Medical Ins. _____ I.D.# _____ Primary Insured's Name _____ D.O.B____/____/____

Primary Insured's S.S.# _____ Pharmacy _____ Location _____ Phone _____

Emergency Contact _____ Relationship _____ Phone # _____

Date of Last Eye Exam _____/_____/_____ Name of Previous Eye Dr. (if new to office) _____

Do you use: [ ]Glasses and/or [ ]Contacts? Do you want new [ ]Glasses [ ]Contacts, for [ ]Regular Use [ ]Reading [ ]Computer [ ]Sports

Do you have a specific visual problem or need? _____

Please check any condition(s) which apply to your health:

[ ]No current Health Problems [ ]Anemia [ ]AIDS/HIV [ ]Anxiety [ ]Arthritis [ ]Asthma [ ]Allergies [ ]Crohn's [ ]Cancer [ ]Diabetes
[ ]Depression [ ]Lupus [ ]Thyroid [ ]Heart [ ]High Blood Pressure [ ]High Cholesterol [ ]Kidney Disease [ ]Head Trauma [ ]Headaches
[ ]Weight Gain/Loss [ ]Pregnant/Nursing [ ]Other _____

Please list any surgeries _____

Please check any condition(s) that apply to your eye health:

[ ]Contact Lens Wearer [ ]Previous Eye Surgery [ ]Cataracts [ ]Dry Eyes [ ]Blurred Vision (distance/near) [ ]Retinal Detachments
[ ]Lasik/RK Surgery [ ]Lazy Eye [ ]Blind Spot [ ]Floaters [ ]Glaucoma [ ]Eye Allergies [ ]Eye Turn [ ]Flashes [ ]Double Vision [ ]Iritis
[ ]Eye Injury [ ]Red Eyes [ ]Light Sensitivity [ ]Macular Degeneration [ ] Other _____

Please list any eye surgeries _____

Please check any condition(s) that may have existed in your family:

[ ]Glaucoma [ ]Diabetes [ ]Cataracts [ ]Eye Cancer [ ]Lazy Eye [ ]Retinal Detachment [ ]Lazy Eye [ ]Migraine Headaches
[ ]Macular Degeneration [ ]Other _____

Tobacco use? Y or N If yes, how much? _____ how long? _____ What type? _____

Alcohol use? Y or N if yes, how much? [ ] Social [ ] More than 1-2 glasses per day Recreational Drug Use? Y or N

Medications (list all medications you take including over the counter, vitamins, supplements, oral contraceptives):

_____

Please list any drug allergies: _____

Patient/Guardian signature _____ Signed Date: _____