

Welcome to Avery Eye Care Center

Today's Date: _____

PATIENT INFORMATION	
Name _____	
Street _____	
City _____	State _____ Zip _____
Date of Birth _____	Age _____ M _____ F _____
Social Security # _____	
Home Phone # _____	Work Phone # _____
Cell Phone # _____	Fax # _____
E-mail Address _____	
Employer _____	
Occupation _____	
Spouses (or Parent's) Name _____	

INSURANCE INFORMATION
Vision Insurance _____
Medical Insurance _____

REFERRAL INFORMATION
How did you hear about our office? <input type="checkbox"/> Relative or Friend If so, who? _____ <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Office Sign <input type="checkbox"/> Insurance List

SOCIAL HISTORY
Do you use: <input type="checkbox"/> Cigarettes/ Tobacco <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs <input type="checkbox"/> None

PERSONAL/FAMILY MEDICAL HISTORY			
Is there a Personal or Family Medical History for any that follow?			
<table style="display: inline-table; border: none;"> <tr> <td style="padding: 0 10px;"><u>Self</u></td> <td style="padding: 0 10px;"><u>Family</u></td> <td style="padding: 0 10px;"><u>Relationship</u></td> </tr> </table>	<u>Self</u>	<u>Family</u>	<u>Relationship</u>
<u>Self</u>	<u>Family</u>	<u>Relationship</u>	

Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

PATIENT MEDICAL HISTORY
Name of Family Physician _____
Date of Last Physical Check-up _____
CURRENT MEDICATIONS (Rx or Over the Counter):
<u>Name of Medication</u>
Antihistamines <input type="checkbox"/>
Arthritis <input type="checkbox"/>
Diabetes <input type="checkbox"/>
Eye Drops <input type="checkbox"/>
High Blood Pressure <input type="checkbox"/>
Thyroid <input type="checkbox"/>
OTHER <input type="checkbox"/>

MEDICATION ALLERGIES: _____

PATIENT EYE HISTORY

Date of Last Eye Exam _____

What was the major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

What other family members are our patients? _____

Have you had LASIK surgery? Yes No

Are you interested in Laser Vision Correction? Yes No

Do you currently wear contact lenses? Yes No

If yes, what kind? _____

If no, have you ever tried contact lenses? Yes No

Do you experience or have you experienced any of the following?

<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Eye Injury
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> Floaters/Spots
<input type="checkbox"/> Headaches	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Light Sensitive
<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Poor Night Vision	<input type="checkbox"/> Red Eyes
<input type="checkbox"/> Watery Eyes		

LIFESTYLES		
Which of the following do you enjoy?		
<input type="checkbox"/> Sports	<input type="checkbox"/> Musical Instruments	<input type="checkbox"/> Reading
<input type="checkbox"/> Painting/Crafts	<input type="checkbox"/> Hunting	<input type="checkbox"/> Fishing
<input type="checkbox"/> Sewing/Knitting	<input type="checkbox"/> Boating/Sailing	<input type="checkbox"/> Flying

Do you work on the computer? Yes No

Do you spend a lot of time outdoors? Yes No