

brentwoodeyecare
an optometry group

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Welcome to Our Office

Patient's name
Mr. Mrs. Ms. Miss. _____
Today's Date _____
Spouse or Parent _____
Child(ren)'s Name(s) _____ Age _____
_____ Age _____
Mailing Address _____
City, State, Zip _____
Date of birth. _____ Age _____ Sex : F M
Home Phone _____ Cell _____
Work Phone _____ ext. _____

PATIENT'S MEDICAL HISTORY

- | | | |
|------------|-----------------|---------------------|
| Allergies | Arthritis | Heart Disease |
| Asthma | Cancer | Skin Disorder |
| Diabetes | Cataracts | High Blood Pressure |
| Eye Injury | Eye Surgery | Glaucoma |
| Nerves | Kidney Problems | |
| Other | _____ | |

CURRENT MEDICATIONS (Rx or over the counter)
Medication Name

- | | |
|----------------------------|-------|
| Antihistamines | _____ |
| Blood Pressure Pills | _____ |
| Diuretic (water pill) | _____ |
| Oral Contraceptives | _____ |
| Sleeping Tablets | _____ |
| Eye Drops | _____ |
| Others | _____ |
| Allergies to Medicines | _____ |
| Date of Last Physical Exam | _____ |
| Name of Physician | _____ |
| Date of Last Eye Exam | _____ |

FAMILY MEDICAL HISTORY

Relationship to Patient

- | | |
|------------------|-------|
| Blindness | _____ |
| Glaucoma | _____ |
| Diabetes | _____ |
| High Cholesterol | _____ |
| Other | _____ |

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

Yes, I would like to discuss my Social History information directly with my doctor.

Yes No Do you use tobacco products?
Yes No Do you drink alcohol?

Employer (or School) _____
Occupation (or grade) _____
What is the major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

Vision Insurance: Medicare
 VSP
 None

Member ID/SS# _____
Member ID/SS# _____

Do you have double coverage? Yes No

How will you settle your account today?

Check Credit Card Cash

Do you experience... (check those that apply)

- | | |
|---------------------|----------------------------|
| Burning | Uncomfortable Glasses |
| Itchiness | Sudden Loss of Vision |
| Nausea | Sensitivity to Light |
| Watery Eyes | Fainting or Dizziness |
| Double Vision | Blurry Distance Vision |
| Flashes of Light | Blurry Near |
| Glare or Reflection | Gritty Feeling in Eyes |
| Soreness | Objects Floating in Vision |
| Eye Strain | Trouble Seeing at Night |
| Headaches | Dryness |
| Redness | Other |

VISUAL NEEDS

Do You ... (check the box if your answer is yes)

- Work at a computer for long periods of time?
- Have only one pair of glasses?
- Want information on thinner, lighter lenses?
- Use bifocals?
- Want information on lineless bifocals?
- Prefer not to wear your glasses at times?
- Spend a lot of time outdoors?
- Ever find a need for prescription sunglasses?
- Have problems with glare or reflections (ex: night driving)?
- Do work requiring safety glasses?
- Participate in sport activities? What? _____
- Want more information about corrective vision surgery?
- Wear or ever tried wearing contacts? What kind? _____

By signing below, I agree to accept financial responsibility for all services and materials not covered by my vision insurance provider.

Signature: _____ **Date:** _____

By signing below, I agree to accept financial responsibility for all services and materials not covered by my vision insurance provider.

Signature: _____ **Date:** _____