☐ Web Page: Which Website?

WELCOME TO OUR OFFICE

Today's Date:

_____

PATIENT INFORMATION

Last: _____

First: _____ MI: _____

Patient's SSN: _____

Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female

Street: _____

City: _____ State: ____ Zip _____

Race: _____ Ethnicity: _____

Primary Language: ☐ English ☐ Other: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Email: _____

Cell Phone/ Primary Contact: ( ) _____

Employer/School: _____

Occupation/Grade: _____

Spouse/Parent's Name: _____

Spouse/Parent's Work: _____

WHOM SHOULD WE NOTIFY IN CASE OF AN EMERGENCY?

_____ ( ) _____

Name *Telephone* *Rela*

What is the major purpose of this visit?

- _____

Any problems with your current contact lenses or gla

- _____

Interested in LASER Vision Correction? (LASIK)

- _____

VERY IMPORTANT!

Whom may we thank for referring you to our office?

☐ Current Patient:

_____

☐ Referring Doctor: _____

Primary Care Physician or Other Medical

☐ Referring Optometrist:_____

City: _____ State: _____

☐ Name of friend or relative _____

IF NOT REFERRED, HOW DID YOU CHOOSE OUR OFFICE?

☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Yellow Pages: Which Directory?

At EyeLux Optometry, we are professionals committed to providing you with the most comprehensive eyecare available in a respectful and compassionate atmosphere. We also promise to educate you thoroughly regarding your vision and eye health needs.

We are dedicated to actively advancing our knowledge and expertise in the field of eyecare so we can offer you leading-edge technology and products, thus maximizing your quality of life.

As a result of our united efforts, we will provide you with the highest level of service and value to ensure that our relationship with you, your family, and your friends lasts for many years to come.

INSURANCE INFORMATION

Vision Insurance:

_____

Subscriber Name:

_____

Subscriber SSN: _____

Subscriber Birth date:

_____

Primary Medical Insurance

_____

Subscriber Name

_____

Subscriber SSN

_____

Subscriber Birth Date

_____

PHYSICIAN & PHARMACY

I Y
CHARGES NOT COVERED BY MEDICAL OR VISION INSURANCE:

_____

(SIGNATURE) (DATE)

Patient Name: _____ Today's Date: _____

Birth Date: _____

A PAST OCULAR HISTORY:
Have you been diagnosed with ANY eye problems?
(e.g. cataracts, glaucoma, macular degeneration, retinal problems, etc.)

▼ ❍ Yes ❍ No

Please list all OCULAR PROBLEMS:	Date	Left Eye/ Right Eye / Both?

B PAST OCULAR PROCEDURES:
Have you had ANY ocular surgeries or procedures?
(e.g. cataract surgery, glaucoma surgery, laser surgery, LASIK, retinal surgery, etc.)

▼ ❍ Yes ❍ No

Please list all previous OCULAR PROCEDURES:	Date	Left Eye/ Right Eye / Both?

C PAST SYSTEMIC ILLNESSES:
Have you had ANY past systemic illnesses?
(e.g. thyroid problems, glaucoma, diabetes, hypertension (high blood pressure), heart disease, cancer, respiratory issues, etc.)

▼ ❍ Yes ❍ No

Please list ALL PAST MEDICAL ILLNESSES:

D HEAD/OCULAR TRAUMA
Have you had ANY of the past head or ocular trauma?
(e.g. falls, head concussions, motor vehicle accidents, etc.)

▼ ❍ Yes ❍ No

Please list all PAST HEAD/OCULAR TRAUMA:	Date of injury

E PAST BODILY SURGERIES
Have you had any general/bodily surgeries or procedures?
Please list ALL past surgeries

▼ ❍ Yes ❍ No

Please list all previous GENERAL SURGERIES:	Date of surgery

F FAMILY AND SOCIAL HISTORY

Do any of your family members have ANY medical or eye diseases?
If YES, please note relationship to patient.

Disease	Yes	No	Relationship
Macular degeneration	○	○	
Glaucoma	○	○	
Retinal problems	○	○	
Lazy eye	○	○	
Blindness	○	○	
Diabetes	○	○	
High blood pressure	○	○	
Heart disease	○	○	
Respiratory disease	○	○	
Cancer	○	○	
Thyroid/Autoimmune disease	○	○	

Follow Up Questions

Do you smoke? ○ Yes ○ No
If yes, how much? ____ packs per day?

Former smoker? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No
If yes, how much? ____ drinks per day?

Comments:_____

_____

_____

__

G REVIEW OF THE SYSTEMS

Do you currently have any of the following problems?

	Questions	Yes	No	If YES, please explain
1.	Do you have any allergies to any medication?	○	○	
2.	Constitutional (fever, weight loss, fatigue, other)	○	○	
3.	Eyes (glaucoma, cataract, lazy eye, retina problems, other – please specify)	○	○	
4.	Ear | Nose | Mouth | Throat (hearing loss, sinus problems, sore throat, difficulty breathing)	○	○	
5.	Cardiovascular (heart problems, chest pain, irregular heart beat)	○	○	
6.	Respiratory (asthma, shortness of breath, wheezing , coughing)	○	○	
7.	Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	○	○	
8.	Genitourinary (urinary problems, blood in urine)	○	○	
9.	Integumentary (skin rashes, excessive dryness)	○	○	
10.	Musculoskeletal (muscle aches, joint pain, swollen joints)	○	○	
11.	Neurological (numbness, weakness, headaches, paralysis)	○	○	

12.	Hematologic/ Lymphatic (blood disorders, leukemia)	○	○	
13.	Allergic/ Immunologic (hay fever, allergies)	○	○	
14.	Endocrine (thyroid problems, diabetes, autoimmune disease)	○	○	

H CURRENT MEDICATIONS

Are you currently taking ANY medications or vitamins/supplements?
If YES, please list all with included milligrams and times per day if known:

Patient Name: _____ Today's Date: _____

Birth Date: _____

Medication Name	Strength (mg.)	Frequency Taken

Thank you!