

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? _____

	Self	Family	Relationship
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):	Name of Medication
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?
 Blurry Vision Burning Double Vision
 Dry Eyes Eye Infection Eye Injury
 Eye Strain Flashes of Light Floaters/Spots
 Headaches Itchy Eyes Light Sensitive
 Loss of Vision Poor Night Vision Red Eyes
 Watery Eyes

LIFESTYLES

Which of the following do you enjoy?
 Sports Musical Instruments Reading
 Painting/Crafts Hunting Fishing
 Sewing/Knitting Boating/Sailing Flying

Do you work on the computer? Yes No
 Do you spend a lot of time outdoors? Yes No