See More Eye Care OD, PLLC

PATIENT INFORMATION

First Name (Nombre) _____

Last Name (Apellido) _____

Date of Birth (Fecha De Nacimiento) _____ Age _____

Occupation (Ocupación) _____

Please list your hobbies and activities:

_____

What is the main reason for your visit today?

_____

When was your last complete eye exam? ☐ Less then 6 months
☐ 1 year ☐ 2 years ☐ more then 2 years ☐ Never

Where was your last complete eye exam?

_____

Read each statement. Check "yes" if true or "no" if false.

Yes	No	
☐	☐	I am pregnant.
☐	☐	I have difficulty with night vision or night driving.
☐	☐	I am excessively bothered by sunlight, bright lights, or glare.
☐	☐	I spend time at a computer
☐	☐	I am troubled with frequent headaches.
☐	☐	I have had a recent illness or been hospitalized in the last 2 years. *If YES, why?* _____
☐	☐	I have environmental allergies, sinus trouble, or hay fever.
☐	☐	I am allergic to medications. *If YES, what medications?* _____
☐	☐	I have had an eye infection, eye injury, or eye surgery (including Lasik). *If YES, when?* _____
☐	☐	I have had a head injury in the past. *If YES, when?* _____
☐	☐	I experience flashes of light. *If YES, how often?* _____
☐	☐	I use eye drops. *If YES, please list?* _____
☐	☐	I currently have double vision. *If YES, when did it start?* _____
☐	☐	I have worn contact lenses in the past but no longer wear them currently. *If YES, what type of contact lens?* _____
☐	☐	I currently wear contact lenses. *If YES, what brand and prescription (if known)?* _____

Rate your current lens comfort (if applicable).
☐ Good ☐ Poor

Rate your current vision with contact lenses.
☐ Clear ☐ Blurred

What contact solution(s) do you use?
☐ Biotrue ☐ Optifree ☐ Clear Care ☐ Other: _____

HIPAA ACKNOWLEDGMENT	
Customer Received	**Customer Refused**

CONTACT INFORMATION

Address (Dirección) _____

Address Line 2 _____

City (Ciudad) _____

State (Estado) _____

Zip Code (Código Postal) _____

Cell Phone (Teléfono De Celular) _____

Other Phone (Otro Teléfono) _____

Preferred Method of Contact ☐ Cell Phone ☐ Other Phone

Email (Correo Electrónico) _____

MEDICAL AND OCULAR HISTORY

Check "yes" if applicable. Check "no" if not applicable.

	You (Patient)		Blood Relative(s)	Relation to patient
	Yes	No	Yes	
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Heart Problems	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Lazy or Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____

Other ocular(eye) problems

_____

_____

Other general health problems

_____

_____

List any medications you are currently taking (including aspirin, birth control, and OTC medications)

_____

_____

_____

_____

SOCIAL HISTORY

Check "yes" if applicable. Check "no" if not applicable.

	Yes	No	
Married	☐	☐	_____
Tobacco History	☐	☐	_____
Tobacco Current Use	☐	☐	_____
Alcohol Use	☐	☐	_____