SEE MORE EYE CARE OD, PLLC INTAKE FORM PATIENT MEDICAL & CONTACT INFORMATION

FIRST NAME_____

LAST NAME_____

AGE, DATE OF BIRTH _____, _____

CELL PHONE_____

EMAIL_____

GENDER: ❑ MALE ❑ FEMALE

Preferred Method of Contact:

❑ Phone Call ❑ Text ❑ Email ❑ Other?_____

FULL ADDRESS_____

_____

_____

What is the main reason for your visit today?

- ☐ **Comprehensive Examination**
- ☐ **Contact Lenses**
- ☐ **Dry/Itchy Eyes**
- ☐ **Other?**_____

Last Eye Exam & Doctor or Office Name?

_____,_____

OCCUPATION/WORK_____

HOBBIES/ACTIVITIES_____

_____

PT & FAMILY MEDICAL & OCULAR HISTORY
Read Each State in Full, Check if Applicable

- ☐ **I AM PREGNANT**
- ☐ **I HAVE DIFFICULTY DRIVING (NIGHT TIME)**
- ☐ **I AM EXCESSIVELY BOTHERED BY GLARE**
- ☐ **I SPEND MORE THAN 4 HOURS ON A COMPUTER SCREEN DAILY**
- ☐ **I HAVE FREQUEST HEADACHES/MIGRAINES**
- ☐ **I have had a recent illness or hospitalization. If Yes, When & Why?**_____
- ☐ **I have environmental allergies**
- ☐ **I am ALLERGIC TO MEDICATIONS. If Yes, Which Medications?**

_____

- ☐ **I am TAKING MEDICATIONS. If Yes, Which Medications? (Include Aspirin, Birth Control, and OTC Meds or Supplements)**

_____

- ☐ **I have had an eye infection, eye injury, or eye surgery (INCLUDE LASIK). If Yes, When?**_____
- ☐ **I have had a head injury in the past. If Yes, When?**_____
- ☐ **I use Eye Drops. If Yes, Which?**_____
- ☐ **I experience floaters & flashes of Light**
- ☐ **I experience double vision or ghost images**
- ☐ **I currently wear contact lenses**
- ☐ **I used to wear contact lenses or never worn**
- ☐ **I am diagnosed with Diabetes (T1 or T2)**
- ☐ **I am diagnosed with High Blood Pressure**
- ☐ **I am diagnosed with High Cholesterol**
- ☐ **I have a history of other Ocular or Medical Disease? AMD, Retinal Detachment, Glaucoma?**

_____

FAMILY MEDICAL HISTORY:_____

FAMILY OCULAR HISTORY:_____

Social Hx:

❑ MARRIED ❑ SINGLE

- ☐ ALCOHOL USE:_____
- ☐ CURRENT SMOKER?_____
- ☐ NEVER SMOKER
- ☐ EX SMOKER