Precision Eye Care

PATIENT HISTORY INTAKE FORM

FIRST NAME: _____ LAST NAME: _____ MI: _____

Address: _____ City: _____ State: __ Zip: _____

Primary Phone: _____ Secondary Phone: _____ Gender: M / F

Date of Birth: _____ Family Doctor: _____ Location: _____

Occupation: _____ Employer: _____ Age: _____

Email: _____ *we will only use this email on rare occasions to contact you for appointment related information

Have you been seen in our office before (this office was previously Dr. David Chambers)? Y / N

Referred by: _____ Last Eye Exam Date: _____ From Dr.: _____

Have you ever worn glasses? Y / N Do you wear glasses now? Y / N

Reason for today's visit (check all that apply):

____ General check-up ____ Blurred distance vision ____ Pain in eyes ____ Want new glasses Rx

____ Diabetic eye exam ____ Blurred near vision ____ Itching in eyes ____ Want contact lenses

____ Lost/Broken glasses ____ Eyestrain ____ Headache ____ other: _____

❒ ← **I would prefer not to be dilated at today's visit. [Dilation may cause a temporary/reversible blurring of vision]**

Do you take any medications? Please list: _____

(circle): diabetic meds blood pressure meds cholesterol meds thyroid meds antihistamines birth control

Do you have any allergies? If yes, please list: _____

Please mark if you or a family member have ever had any of the following conditions.

	YOU		**Family Member**	Who?
Diabetes	❒	_____	❒	_____
High Blood Pressure	❒	_____	❒	_____
Heart Disease	❒	_____	❒	_____
Seasonal Allergies	❒	_____	❒	_____
Thyroid problems	❒	_____	❒	_____
Arthritis	❒	_____	❒	_____
HIV or AIDS	❒	_____	❒	_____
Glaucoma	❒	_____	❒	_____
Cataracts	❒	_____	❒	_____
Eye Surgery or Trauma	❒	_____	❒	_____

Are you currently pregnant? Y / N Are you currently breast-feeding? Y / N

Have you ever worn contact lenses? Y / N Do you wear contact lenses now? Y / N

Brand of contact lenses worn: _____ Powers/Prescription: _____

How old is your current pair?: _____ Type of solution used: _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Name (please print): _____ **Date:** _____

Parent/Guardian Signature: _____

*****By signing I agree to be financially responsible for my or my child's exam and material fees**