

Welcome to our office

Patient _____
Address _____

Home phone (____) _____
Work phone (____) _____ ext _____
Sex: M F
Birthdate _____ Age _____
Occupation _____
Employer _____
Account responsibility _____
Marital status _____ Spouse's name _____
Whom may we thank for referring you? _____

Physician's Name _____
Date of last eye exam _____
Name of eye doctor _____
Do you wear glasses? Y N
____ All the time ____ Occasionally ____ Reading
____ Driving ____ TV
Do you wear contacts? Y N
Type _____
Are you interested in contacts? _____
Describe any problems you have with your contacts.

Are you interested in changing your eye color? _____

School attending _____
Teacher _____
Parents names _____

Do you use:
Cigarettes/tobacco? Y N
Alcohol? Y N
Other substances? Y N

List medications you are currently taking,
including eye drops:

List your allergies to medications or other
substances:

