State Street Eye
SEE BETTER. LOOK GREAT.

Provider:	
Printed:	

Dear patient:

We welcome you to our practice and ask that you kindly complete or correct all information on this form.

PATIENT INFORMATION

PATIENT NAME:		SEX:	SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:	DATE OF LAST EYE EXAM
CITY, STATE & ZIP:		EMAIL:	
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
EMPLOYER:		OCCUPATION:	
EMPLOYER'S ADDRESS:		PRIMARY CARE PHYSICIAN:	DATE OF LAST PHYSICAL EXAM:
WHAT IS THE REASON FOR YOUR VISIT TODAY?		PRIMARY CARE PHYSICIAN'S PHONE:	

Do you or your family have any history of the following conditions (check all that apply)?:

Self	Family	
❑	❑	Glaucoma
❑	❑	Cataracts
❑	❑	Diabetes
❑	❑	High Blood Pressure
❑	❑	Macular Degeneration
❑	❑	Heart Problems
❑	❑	Retinal Degeneration
❑	❑	Stroke
❑	❑	Thyroid Condition
❑	❑	Crossed Eye/Eye Turn
❑	❑	Lazy eye
❑	❑	Asthma/ Allergies
❑	❑	Color Blindness
❑	❑	Arthritis
❑	❑	Tuberculosis
❑	❑	HIV
❑	❑	Hepatitis
❑	❑	Cancer
❑	❑	Neuromuscular
❑	❑	Blindness
❑	❑	Other:

_____

_____

Do you currently have any of the following symptoms (check all that apply)?:

- ❑ Blurry distance vision
- ❑ Poor night vision
- ❑ Eye Strain
- ❑ Blurry Near Vision
- ❑ Trouble Reading
- ❑ Itchy Eyes
- ❑ Discharge
- ❑ Watering
- ❑ Pain in the eye
- ❑ Burning eyes
- ❑ Sandy/dry eyes
- ❑ Red Eyes
- ❑ Glare/reflections
- ❑ Discomfort in sunlight
- ❑ Double vision
- ❑ Floaters or spots in vision
- ❑ Flashes of light
- ❑ Temporary loss of vision
- ❑ Eye injury
- ❑ History of wearing an eye patch
- ❑ History of eye surgery
- ❑ Headaches
- ❑ Dental Abscess

Are you interested in any of the following (check all that apply)?:

- ❑ New spectacles
- ❑ Contact lenses
- ❑ Colored contact lens
- ❑ Sunglasses
- ❑ Clip-ons
- ❑ Safety glasses
- ❑ Sports goggles
- ❑ Lasik

How were you referred to us?

- ❑ Family doctor
- ❑ Website .....
- ❑ Insurance company
- ❑ Another patient
- ❑ _____

MEDICATIONS (INCLUDING OVER THE COUNTER):

SURGERIES:

ALLERGIES:

ALLERGIES TO MEDICATIONS:

HEIGHT:

WEIGHT:

SOCIAL HISTORY (CURRENTLY OR IN THE PAST):

- ❑ Alcohol abuse
- ❑ Drug use
- ❑ Tobacco use

Number of cigarettes/day:

_____

Date quit:_____

- ❑ Other:

_____

_____

_____