Patient Information

Last name: _____ First name: _____ M.I.: _____

Preferred Name: _____ Date of birth: _____ Age: _____ Gender: _____

Street address: _____ Home phone: _____

City: _____ State: _____ ZIP Code: _____ Cell phone: _____

Occupation: _____ Employer: _____ Work phone: _____

Email Address: _____ *(Email will be used for appointment reminders & newsletter)*

Name of guardian if patient is a minor: _____

How did you hear about our office? ◯ Family/Friend ◯ Insurance ◯ Drive/Walk By ◯ Google ◯ Other
◯ AltitudeOptometry.com ◯ LensCrafters.com ◯ Advertisement

Whom can we thank for your referral today? _____

Do you participate in any hobbies, sports, or special activities? _____

Insurance Information

Please list your vision and medical insurance. Please give your insurance card(s) to the receptionist--

Do you have vision insurance? ◯ Yes ◯ No If yes, insurance carrier: _____

Do you have health insurance? ◯ Yes ◯ No If yes, insurance carrier: _____

Do you have Medicare? ◯ Yes ◯ No

Medical History

Do you have allergies to any medication? ◯ Yes ◯ No If yes, please list here: _____

List any medications you take or eye drops you use, and include dosages, if known. Include over-the-counter medications, home remedies, aspirin, oral contraceptives, vitamins, etc. _____

List all major injuries, surgeries, and/or hospitalizations: _____

Are you pregnant? ◯ Yes ◯ No Are you nursing? ◯ Yes ◯ No

Approximate date of last eye exam? If you are not sure, please estimate. _____

Do you wear glasses? ◯ Yes ◯ No If yes, how old is your current pair? _____

Do you wear sunglasses? ◯ Yes ◯ No

Do you wear contacts? ◯ Yes ◯ No If yes, how old is your current pair? _____

If so, what brand of contacts do you wear? _____ Are they comfortable? ◯ Yes ◯ No

If not, are you interested in wearing contacts? ◯ Yes ◯ No

What brand of solution do you use? _____ How often do you replace your contacts? _____

Office Use Only Optomap Digital Imaging ◯ Yes ◯ No | OCT ◯ Yes ◯ No

Do you, or do any of your family members, currently have or have a history of any of the following conditions?

Ocular	Self	Family	Relation
Amblyopia / Lazy Eye	○		
Dry Eye	○		
Eye Surgery or Therapy	○		
Macular Degeneration	○	○	_____
Retinal Detachment / Hole / Repair	○		
Blurred Vision	○		
Loss of Peripheral (side) Vision	○		
Redness	○		
Itching, Burning, and/or Watering	○		
Glare / Light Sensitivity	○		
Chronic Infection of Eye or Lid	○		
Flashes / Floaters in Vision	○		
EAR, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	○		
Sinus Congestion	○		
Runny Nose	○		
Post-Nasal Drip	○		
Chronic Cough	○		
Dry Throat / Mouth	○		
ALLERGIC	○		
RESPIRATORY			
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
VASCULAR / CARDIOVASCULAR			
Diabetes	○	○	_____
Heart Pain	○		
High Blood Pressure	○	○	_____
Vascular Disease	○		
CONSTITUTIONAL			
Fever, Weight Loss / Gain	○		
INTEGUMENTARY			
Skin Problems	○		
ENDOCRINE			
Thyroid / Gland Problems	○		

	Self	Family	Relation
Strabismus / Crossed Eyes	○		
Cataracts or Cataract Surgery	○	○	_____
Eye Injury	○		
Glaucoma	○	○	_____
Blindness / Loss of Vision	○		
Distorted Vision / Halos	○		
Double Vision	○		
Sandy / Gritty Feeling	○		
Foreign Body Sensation	○		
Eye Pain or Soreness	○		
Sties or Chalazion	○		
Tired Eyes	○		
NEUROLOGICAL			
Headaches	○		
Migraines	○		
Seizures	○		
GASTROINTESTINAL			
Chronic Diarrhea	○		
Chronic Constipation	○		
GENITOURINARY			
Genital / Kidney	○		
Bladder problems	○		
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	○		
Muscle Pain	○		
Joint Pain	○		
LYMPHATIC / HEMATOLOGIC			
Anemia	○		
Bleeding Problems	○		
Lupus	○		
Cancer	○	○	_____
IMMUNOLOGIC			
HIV/AIDS	○		
PSYCHIATRIC	○		

If you answered yes to any of the above, or have a condition not listed, please explain _____

_____

Social History

Do you smoke? ○ **Yes:** ____ **packs/day No** ○

Do you consume alcohol? ○ **Yes** ○ **No** ○ **Do you use recreational drugs?** ○ **Yes** ○ **No**

If yes, how often? _____ **If yes, what kind?** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Altitude Optometry, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ **Date:** _____