UONG EYE CARE, P.A.

Patient Name _____ DOB ____/____/_____ Date _____
(Mr/Mrs/Ms/Miss/Dr)

Parent/Guardian _____

Address _____ Apt # _____

City _____ State _____ Zip _____ Age _____ Sex: M / F

Phone: (H) _____ (C) _____ (W) _____

Email _____ SS# _____

Employer: _____ Occupation: _____

Hobbies _____ Hours spent on comp per day? _____

How did you hear about us? _____ Person Referred _____

Health/Medical Insurance: _____ Vision Insurance/ID#: _____

Health Insurance ID# _____ Primary DOB ____/____/_____

Primary/Insured's Name: _____ Primary SS# _____

This examination is for: □ Glasses □ Contacts □ Both □ Others

VISUAL HISTORY:

Date of last eye exam? _____ How old are your glasses if applicable? _____

	Y	N	If Yes, Please specify:
Do you wear contact lenses?			**Brand:**
Do you have any of the following eye problems such as: Glaucoma, Cataract, Macula Degeneration, Retinal Detachment, or Lazy eye, and etc.?			
Does anyone in your family have any of the above listed?			
Have you ever had eye surgery?			

MEDICAL HISTORY:

	Y	N	If Yes, Please specify:
Are you taking any medications?			
Are you allergic to any medications?			
Do you have any of the following conditions: Diabetes, High Blood Pressure, Stroke, Heart Diseases, High Cholesterol, Thyroid, Sickle Cell, Asthma, COPD, Headaches, Migraines, or Pregnant?			
Do any of your family members have the above conditions?			

Do you want your eyes to be dilated? **□Yes** **□ No** **□ Reschedule**

Dilation is part of the examination. It allows your doctor to view a larger area in the back of your eyes. It is highly recommended for patients with diabetes, glaucoma, systemic diseases, high prescription, and those over 55 years old. However, certain side effects may occur such as blurry vision, stinging upon instillation, light sensitive, nausea, and dry mouth. Your eyes will remain dilated for ~4-6 hours. A designated driver is highly recommended.

Signature _____