Desert EyeWorks OPTOMETRY

PATIENT INFORMATION

Please Complete at Each Annual Examination *(Please Print)* Female ☐ Male ☐

Last Name | First Name | Middle Initial

Birth Date | Age | Referred By *(Friend/ Family/flyer/ Insurance)*

Home Address | City | State | Zip

Occupation | Employer Name | Home/cell Phone#

Employer Address | City | State | Zip

SSN# ___ ___ ___ | Drivers Lic# | Email Address

INSURANCE INFORMATION

Will you be using any vision benefits or programs?

Vision Plan Name | Member ID# | Last 4 of SSN#

Insured's Name | Insured's Date of Birth | Patient's Relationship to Insured

PATIENT HISTORY

1. Do you have? *(check all that apply)*
   - ☐ Frequent neck & shoulder pain
   - ☐ Blurred Vision With Glasses Or Contacts
   - ☐ Floater
   - ☐ Pain
   - ☐ Double Vision
   - ☐ Dry Eyes
   - ☐ Itchy Eyes
   - ☐ Flashes Of Light
   - ☐ Eyestrain
   - ☐ Severe Or Frequent Headaches

2. Name of your primary physician: _____ Date of last Physical: _____

3. Age of present glasses: _____ Date of last eye exam: _____

4. Have your eyes been dilated before? Yes ☐ No ☐

5. Do you or any blood relatives *(grandparents, parents, brothers, sisters, and children)* have? *(Please check all that apply)*

	SELF	BLOOD RELATIVES		SELF	BLOOD RELATIVES
Retinal Disease	☐	☐	Lung Disease	☐	☐
Cataracts	☐	☐	Heart Disease	☐	☐
Glaucoma	☐	☐	High Cholesterol	☐	☐
High Blood Pressure	☐	☐	Diabetes	☐	☐
Thyroid Problems	☐	☐			

6. Are you pregnant? *(If applicable)* Yes ☐ No ☐

7. Are you being treated for any medical conditions? Yes ☐ No ☐ *(If Yes, Please List)*

8. Are you taking any medications? Yes ☐ No ☐ *(If Yes, Please List)*

9. Allergies to medications including eye drops? Yes ☐ No ☐

10. History of eye disease, injury or surgery? Yes ☐ No ☐ *(If Yes, Please List)*

PATIENT VERIFICATION

The patient history information that I have provided above is accurate and complete to the best of my knowledge.

Signature _____

Date _____

(If under 18 years of age, parent signature required)