

EyeWish Optometry

"You will see the difference"

Welcome to our office! Please fill out the following. Your responses will be treated as confidential medical information.

Name (Last, First, M.I.) _____

Nickname _____ Gender _____

DOB (MM/DD/YY) _____ Age _____

Home address _____

City _____ State _____ Zip _____

Home phone (_____) _____

Work phone (_____) _____

Cell phone (_____) _____

Email address _____

How do you prefer to be contacted?

Home Work Cell Email

Height _____ inches Weight _____ lbs.

Race _____ Ethnicity _____

Preferred Language _____

Employer _____ Occupation _____

Hobbies _____

How did you learn about our office? _____

Vision Insurance (check one):

None MES Davis Vision VSP

Blue View Vision Medicare Other

Name of insured : _____

Insured's DOB ____/____/____ SSN ____-____-____

Relationship to insured:

Self Spouse/Partner Child Other

Medical Insurance _____

PPO HMO

Name of insured (Last, First) _____

ID # _____

Emergency Contact:

Name _____

Phone (_____) _____

Relationship to patient _____

Eye and Medical History

What is the reason(s) for your visit here today?

Last Eye Exam (Date, Doctor) _____

Do you currently wear glasses? Yes No

Would you like thinner or lighter eyewear? Yes No

Would you rather not wear glasses? Yes No

Do you have sunglasses that filter 100% UVA & UVB rays?

Yes No Not Sure

Are you bothered by glare or reflection, particularly when driving at night? Yes No

Do you wear contact lenses? Yes No

If yes, which type? (Check one) Soft Hard Gas Perm.

Other _____

Lens Brand/Powers _____

Average hours worn/day _____

Cleaning/disinfection solution(s) _____

How often do you sleep in your lenses? _____

At what age did you first start wearing contacts? _____

Do you experience any of the following eye symptoms?

(Check all that apply)

Burning Itching Tearing/watering Pain

Eyestrain Floaters Headaches Glare

Blurry Vision Light flashes Light Sensitivity Double vision

Irritation/Foreign body sensation

Have you ever had any eye injuries or surgeries to your eyes?

Yes No

If yes, please list and indicate which eye(s) and the approximate date(s).

Who/where is your primary care doctor or internist?

When was your last physical exam with your primary care

doctor? _____

Are you being followed by a doctor for any medical condition(s)?

Yes No If yes, please list

Do you use a computer? Yes No

How many hours (average) per day? _____

Do you or any of your relatives have any of the following?

Glaucoma? Who? _____

Cataracts? Who? _____

Macular Degeneration? Who? _____

Eye Injury? Who? _____

Retinal Disease / Detachment? Who? _____

Blindness? Who? _____

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- Strabismus (eye turn)? Who? _____
- Ambyopia? Who? _____
- Diabetes? Who? _____
- Dry Eye? Who? _____
- Cancer? Who? _____
- Heart Disease? Who? _____
- Hypertension? Who? _____
- High Cholesterol? Who? _____
- Kidney Disease? Who? _____
- Stroke? Who? _____
- Thyroid Condition? Who? _____
- Other? Who? _____

Do you smoke? Current Former Never

Do you drink alcohol? Socially Yes No

Please list all of the medications including eyedrops you are currently taking, both prescription and over the counter:

Do you have any allergies to medications? Yes No

If yes, please list

Have you ever had an allergic reaction to drops used in an eye exam? Yes, _____ No

Do you have seasonal allergies/hay fever? Yes No

Do you have any other allergies? Yes No

If yes, please list here: _____

Please initial and date at every visit:

Date _____ Date _____ Date _____

Date _____ Date _____ Date _____

Date _____ Date _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that **EyeWish Optometry** make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that (PLEASE CHECK ONLY ONE):

- I have read or had explained to me **EyeWish Optometry's** Notice of Privacy Practice and agree to continue my care with **EyeWish Optometry** under said terms.
- I was given the opportunity to read **EyeWish Optometry's** Notice of Privacy Practices and declined but wish to continue my care with **EyeWish Optometry** under the terms of **EyeWish Optometry's** privacy policies.
- I have read or had explained to me **EyeWish Optometry's** Notice of Privacy Practice and do not wish to continue my care with **EyeWish Optometry** under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient _____ Date _____

If you are signing as a personal representative of the patient, please indicate your relationship

Representative _____ Relationship to Patient _____