blink EYECARE

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____ MI _____ Sex M F
Street _____
City _____ State _____
Zip Code _____
Date of Birth _____ Age _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
Please circle one:
Race: American Indian Asian Pacific Islander White Other
Ethnicity: Hispanic or Latino Not Hispanic or Latino
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
What is the major purpose of this visit?
_____
Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?
❑ Another Doctor ❑ Insurance List
❑ Saw Sign/Building ❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Patient Medical History

Name of Family Physician _____
Date of Last Physical Check-up _____
What medical conditions are you being treated for:
_____
_____
_____
_____
_____

CURRENT MEDICATIONS (Rx or Over the Counter)
_____
_____
_____
_____
_____
_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications? _____
_____
Do you use Alcohol ❑Yes ❑ No
Do you use Tobacco ❑Yes ❑ No
Smoking status ❑Current ❑Former ❑ Never

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____
Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind? _____
Solutions used _____
Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Eye Surgery

Family Medical/Eye History (Check all that apply)

Relationship	Father	Mother	Brother	Sister	Son	Daughter
Cancer	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Hyperthyroidism	❑	❑	❑	❑	❑	❑
Hypothyroidism	❑	❑	❑	❑	❑	❑
Cataracts	❑	❑	❑	❑	❑	❑
Macular Degeneration	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑

Lifestyle Questions

Do you.....(check box if your answer is yes)
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in trying the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have family members in need of eyecare?

Insurance Information

Please note that most insurance does NOT cover the Contact Service Fees

Vision Insurance _____
Primary Medical Insurance _____

Signature: _____ Date: _____