

RETURNING PATIENT INFORMATION- PLEASE PRINT

Date: _____ Mr. Mrs. Ms. Miss Dr. Rev. Rank: _____

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

Address, phone numbers and email reviewed: **No Changes Made (please initial)** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Email: _____

Would you like to receive our monthly email newsletter? Yes No

Would you like to receive emails reminding you of appointments? Yes No

VISION CORRECTION

Are you planning to get new glasses today? Yes No Only if Prescription Changes

Are you planning to get new contact lenses today? Yes No Only if Prescription Changes

I would like to learn about: Computer Glasses Sports Glasses Sunglasses

Are you interested in finding out more about Laser Vision Correction? Yes No

EYE HISTORY - Are you currently having any of the following symptoms?

	<u>YES</u>	<u>NO</u>	<u>?</u>		<u>YES</u>	<u>NO</u>	<u>?</u>
Fluctuating Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tearing/Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scratchy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list and explain any unmentioned symptoms:

MEDICAL HISTORY

Medical history reviewed ____/____/____: **No Changes** **Changes Made (Initial)** _____

Medication Reviewed: **No Changes** **Changes Made (Initial)** _____

Medical Allergies Reviewed: **No changes made** **Changes made (please initial)** _____

Are you pregnant or nursing? Yes No

Office Use Only

Insurance Signature on file? Yes No

Financial Responsibility on file? Yes No

Doctor's Signature

Date Reviewed