Items marked with RED ✻ are required by government regulation

Patient Demographics

✻ Name (First) _____ (MI) ____ (Last) _____ Age_____

✻ Address_____ City _____ State____ Zip_____

✻ 1st Phone ( ) _____ - _____ [ ] home [ ] cell [ ] work email _____

Primary Doctor_____

* 2nd phone ( ) _____ - _____ [ ] home [ ] cell [ ] work

✻ Communication Preference
[ ] email [ ] mail [ ] phone

Preferred Pharmacy
Name: Phone:
Address:

Responsible Party (if different from patient)

✻ Date of Birth : _____ / _____ / _____ ✻ Gender: Male / Female

✻ SSN (last 4 only) *** - ** - __ __ __ __

✻ Name (First) _____ (MI) ____ (Last) _____

check if same as patient [ ] address [ ] phone [ ] email, otherwise complete below

✻ Address_____ City _____ State____ Zip_____

✻ 1st Phone ( ) _____ - _____ [ ] home [ ] cell [ ] work email _____

2nd phone ( ) _____ - _____ [ ] home [ ] cell [ ] work

Patient Insurance

✻ Ins. Company Name _____ ✻ID # _____

✻ Ins. Company Plan _____ Group # _____

✻ Relationship to Subscriber: [ ]self [ ]parent / guardian [ ]spouse / domestic partner [ ]other

if other than "Self" or "Responsible Party" above please complete below

✻ Subscriber name: _____

✻ Address _____

✻ Phone ( ) _____ - _____ ✻ Date of Birth _____ / _____ / _____

✻ Gender: Male / Female Employer _____

Personal Information

✻ Date of Birth
_____ / _____ / _____

✻ Gender: Male / Female

✻ SSN
__ __ __ - __ __ - __ __ __ __

✻ Race (select multi)
[ ] decline
[ ] Am. Indian / Alaskan Nat.
[ ] Asian
[ ] Black
[ ] Native Hawaiian
[ ] White

✻ Ethnicity
[ ] decline
[ ] Hispanic / Latino
[ ] all others / non-Hispanic

✻ Preferred Language
[ ] English
[ ] Spanish
[ ] _____

✻ Referred By
[ ] employee
[ ] self
[ ] pediatrician / outside doctor
[ ] family member
[ ] insurance
[ ] website
[ ] recall letter
[ ] yelp
[ ] google

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Please Complete Entire Page Every Visit

✲ Medical History

has the patient ever had:

[ ] eye surgery
[ ] misaligned eyes
[ ] "lazy eye"
[ ] glasses / contacts
[ ] glaucoma
[ ] double vision
[ ] droopy eyelid
[ ] retinopathy of prematurity

[ ] autism
[ ] cerebral palsy
[ ] developmental delay
[ ] down's syndrome
[ ] dyslexia
[ ] epilepsy
[ ] genetic abnormality
[ ] hypoxic episode
[ ] hydrocephalus
[ ] low birth weight
[ ] NAS
[ ] premature birth

[ ] arthritis
[ ] asthma
[ ] cancer
[ ] diabetes
[ ] hearing problem
[ ] hepatitis
[ ] high blood pressure
[ ] HIV / AIDS
[ ] Lupus / SLE
[ ] multiple sclerosis
[ ] stroke / TIA
[ ] thyroid disease
[ ] other

_____
_____
_____
_____
_____

✲ Surgical History

list all surgeries: [ ] none

_____
_____
_____
_____
_____
_____
_____
_____

✲ Social History

Tobacco
[ ]no
[ ]yes currently
[ ]yes formerly

✲ Family History

do any of the following run in your family:

M = mother F = father
GM = grandmother
GF = grandfather
S = sibling
(who)

Y( ) N blindness
Y( ) N cataract
Y( ) N color blindness
Y( ) N crossed eyes
Y( ) N glaucoma
Y( ) N lazy eye
Y( ) N other

_____
_____
_____
_____
_____
_____
_____

✲ Medications

list medication allergy(ies) : [ ] none

_____
_____
_____

list current medication(s): [ ] none

medication	*dose*	*reason*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

✲ Review of Systems

is the patient currently experiencing the following: [ ] none

[ ]blurred vision [ ]loss of vision [ ]poor eye contact
[ ]crossed or wandering eye(s) [ ]difference in pupil size / shape
[ ]double vision [ ]droopy eyelid [ ]excessive squinting [ ]eye pain
[ ]eye discharge [ ]eye itching / burning [ ]light sensitivity
[ ]jumping / dancing / wiggling eyes [ ]swelling of eye / eyelid

[ ]ear infections [ ]nasal congestion [ ]sinus problem [ ]hearing problem [ ]clumsiness [ ]stroke [ ]seizure [ ]headache [ ]scalp tenderness
[ ]genetic abnormality [ ]anxiety [ ]depression [ ]poor attention
[ ]declining school / work performance
[ ]chills [ ]weight loss [ ]fever
[ ]heart defect [ ]irregular heartbeat [ ]high blood pressure
[ ]rapid heartbeat [ ]blackouts
[ ]metabolic disease [ ]hormone problem [ ]thyroid problem
[ ]excessive thirst or urination
[ ]Birth mark [ ]rash [ ]skin nodule
[ ]shortness of breath [ ]cough [ ]asthma [ ]seasonal allergy
[ ]hay fever [ ]bleeding [ ]bruising [ ]sickle cell disease
[ ]weakness [ ]arthritis / joint pain [ ]jaundice [ ]tarry stool
[ ]blood in stool [ ]bladder / kidney problem
[ ] is the patient pregnant
[ ]other_____

- - - - - - FOR INTERNAL USE ONLY - - - - - -

To Do		Done
x1 x2 x3 [ ]	magic	[ ] x1 x2 x3
x1 x2 x3 [ ]	cyclogyl 1%	[ ] x1 x2 x3
[ ]	cyclomydril	[ ]
[ ]	tropic 1%	[ ]
[ ]	pheny 2.5%	[ ]
[ ]	_____	[ ]

followup _____ day / week / month / year
refraction / muscle / DM / glaucoma eval /
re-check. [ ] dilated [ ] non-dilated

_____

[ ] sm refraction
[ ] lrg refraction

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[ ] Ortopad M F Jr Med Reg
[ ] Ocusoft scrub
[ ] DERM mask