PATIENT INFORMATION FORM

coral eyes OPTICAL

DATE: _____

Please Print

PATIENT INFROMATION			
TITLE	**NAME**		
Miss Mr. Mrs. Ms. Other _____	Last _____	First _____	MI _____
MAILING ADDRESS	Address _____	City _____	State Zip Code _____ _____
PHONE NUMBER	Home ( )	Cell/Work ( )	Email Address
BIRTH DATE / /	**SEX** ☐Female ☐Male	**PATIENT SS#** / /	**Occupation/Hobbies**
PATIENT SIGNATURE (Parent/Gaurdian if <18 years old) _____			

INSURANCE INFORMATION
Vision Ins. _____ Medical Ins. _____
Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____ ***(If different from self)*** Name _____ D.O.B. ___/___/____ SS# ___/___/____

MEDICAL HISTORY

Reason for visit: _____

EYE HEALTH HISTORY

Do you wear glasses? ☐ Yes ☐ No

If yes, how often?

☐ All day ☐ Reading
☐ Driving ☐ TV/Movies
☐ Computer ☐ Occasionally

Do you wear contact lenses? ☐ Yes ☐ No

If yes:

Type: ☐ Soft ☐ Gas Perm

Hours per day: _____

How often do you **sleep** in contacts? _____

How often do you **replace** contacts? _____

Check the box next to any of these symptoms you have had:

☐ Blurry Distance Vision
☐ Blurry Near Vision
☐ Loss of Vision
☐ Floaters/Spots
☐ Seeing Flashes
☐ Eyestrain
☐ Dry Eyes
☐ Red Eyes
☐ Watery Eyes
☐ Burning Eyes
☐ Discharge
☐ Itchy Eyes
☐ Light Sensitive
☐ Twitching Eyelid
☐ Seeing Halos
☐ Headaches
☐ Eye Injury
☐ Double Vision
☐ Other:_____
_____

GENERAL HEALTH HISTORY

Date of last physical: _____

List all medications currently taking: _____

_____

_____

_____

Allergies to medications: _____

_____

Check box if you and/or your family member have the following conditions:

Condition	Self	Family
AIDS/HIV	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Blindness	☐	☐
Cancer	☐	☐
Cataract	☐	☐
Diabetes	☐	☐
Eye Surgery	☐	☐
Glaucoma	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Lazy Eye	☐	☐
Lupus	☐	☐
Migraines	☐	☐
Retinal Detachment	☐	☐
Stroke	☐	☐
Thyroid Conditions	☐	☐
Turned Eyes	☐	☐

Other: _____

Are you pregnant: ☐ Yes ☐ No
Tobacco use: ☐ Yes ☐ No
Alcohol use: ☐ Yes ☐ No
Drug use: ☐ Yes ☐ No