

PATIENT FACT SHEET

Date _____

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ Zip _____

Age _____ Date of Birth _____ Marital Status _____ SS# _____

Home Phone _____ Leisure Activities _____

Work Phone _____ Occupation _____ Employer _____

Please check if you have, or have had any of the following. If you have a family history of any of the following, place an "F" after those that apply.

<input type="checkbox"/>	Eye injury	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
<input type="checkbox"/>	Crossed eye	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	Concussion	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	AIDS	<input type="checkbox"/>
<input type="checkbox"/>	Lazy eye	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Drug allergies	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>
<input type="checkbox"/>	Foreign body in eye	<input type="checkbox"/>	Respiratory problems	<input type="checkbox"/>	Smoking	<input type="checkbox"/>
<input type="checkbox"/>	Eye surgery	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>
<input type="checkbox"/>	Eye infection	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>

Do you wear glasses? _____ Do you wear them full or part time? _____

Do you wear contact lenses? _____ If so, what type? _____

Date of last eye exam _____ By whom? _____

Please list current medications _____

Is there anything else about your health the doctor should know? _____

Name of major medical insurance company _____

Name of secondary insurance if applicable _____

Name of vision insurance company _____

Head of household (person responsible of payment) _____

Whom may we thank for referring you to our office? _____

What is the main reason for your visit today? _____