DATE: _____

NAME: _____

DATE OF BIRTH: _____ AGE:_____

RES. ADDRESS: _____ RES. PHONE/CELL: _____

EMPLOYED BY:_____ BUS. PHONE: _____

OCCUPATION: _____ EMAIL: _____

SPOUSE/PARTNER NAME: _____

PRIMARY CARE PHYSICIAN: _____ PCP PH#: _____

INSURANCE NAME AND POLICY NUMBER:_____

SUBSCRIBER NAME/ID: _____

Do you have any history of the following?

☐ High Blood Pressure ☐ Tuberculosis ☐ Heart Trouble ☐ Ear Troubles ☐ Glaucoma

☐ Rheumatic Fever ☐ Diabetes ☐ Blood Disease ☐ Kidney/Liver Involvement ☐ Eye Disorder

☐ Cancer ☐ Anemia ☐ Arthritis ☐ Strabismus/Amblyopia (Turned or Lazy Eye)

☐ Head Injury ☐Asthma ☐ Other _____

Has anyone in your family had the following?

☐ High Blood Pressure ☐ Eye Disease ☐ Heart Disease ☐ Blindness ☐ Strabismus (Turned Eye)

Are you sensitive or allergic to any medications? ☐ No ☐Yes; If yes, please name_____

Are you under a doctor's care? ☐ No ☐ Yes; If yes, why?_____

Are you taking any medications now? ☐ No ☐ Yes; If yes, for what purposes? _____

Please list the medications: _____

Are you taking any hormones, including Birth Control Pills? ☐ No ☐ Yes

Have you ever worn contact lens? ☐ No ☐ Yes; If yes, which brand? _____

If you use contact lenses which cleansing solution do you use? _____

Any surgeries? Eye injury/ disease? Head trauma? _____

Date of Last Exam: _____ By Whom: _____

Whom may we thank for referring you? _____

While we will make every effort to verify and confirm your insurance, it is your responsibility to understand all conditions of your insurance plan.

I was shown and understand the privacy policy (HIPPA Privacy Act). _____

----------FOR OFFICE USE ONLY----------

Chief Complaint & History: _____

_____

_____

_____

External Exam

Cover Test Dist. _____ 16" _____
CNP PERRLA DC -MG DSVP GFP

Stereopsis: _____SC_/ CC _____ Randot

Color Vision: _____ / _____
Ishihara

DFE @ _____

- ☐ w/ 1% Tropicamide
- ☐ w/ 1% Cyclopentolate

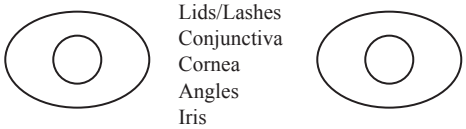
☐ S.E. of DFE explained (near blur, photophobia, mydriasis)

☐ Patient refused

☐ Optos

Slit Lamp & FL.

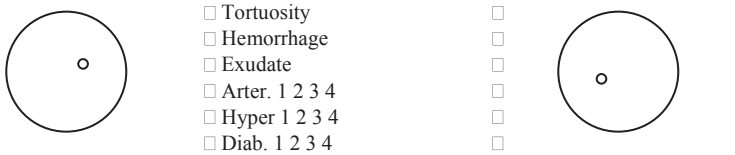
O.D. O.S.



Lids/Lashes
Conjunctiva
Cornea
Angles
Iris
AIC

Ophthalmoscopy BIO / 90D

O.D. O.S.



WNL	NWNL
☐ Tortuosity	☐
☐ Hemorrhage	☐
☐ Exudate	☐
☐ Arter. 1 2 3 4	☐
☐ Hyper 1 2 3 4	☐
☐ Diab. 1 2 3 4	☐
☐ Chor Old New 1 2 3 4	☐
☐ Macular Deg	☐

Keratometry
O.D. _____ 20 _____
O.S. _____ 20 _____

Present RX.
O.D._____
O.S. _____

Static
O.D._____
O.S. _____

Subj
O.D. _____ 20 _____ J
O.S. _____ 20 _____ J

Phorias

Dist	E.X.	Hyo.	R.L.
Dist	E.X.	Hyp.	R.L.

Tonometry: Goldman / Non-Contact / DP

Denied / Contra / Deferred

O.D. O.S. A.M. / P.M. B.P /

_____

	C/D	A/V	HR	AB	LENS	MAC	PER
O.D.							
O.S.							

CL trials to order: _____

O.D. _____

O.S. _____

Contact Lenses

- ☐ Fit
- ☐ Comfort
- ☐ VA

Final Eyeglass RX.

O.D._____ 20 _____ J

O.S. _____ 20 _____ J

Final Contact Lens RX.

_____

_____

Notes: **A.** _____ **P.** _____

_____

_____

_____

_____

_____

_____

_____

RTC: _____