ONLINE WELCOME FORM

Please take a few minutes to complete this Patient Welcome Form before you visit our office for the first time. Once you fill in the information, click on the "Submit" button to e-mail it to our office or bring a copy with you to your next appointment.

Complete Your Personal Information

Salutation ○ Mr. ○ Mrs. ○ Ms. ○ Dr. ○ Miss. ○ Master ○ Rev.

First Name* MI

Last Name*

Preferred Name

Address City

State Zip

Home Phone Work Phone

Social Security Number Phone Ext.:

Email Address* Date of Birth (MM/DD/YYYY)*

Patient's Gender ○ Male ○ Female

Spouse/Parent Name Guardian

Account Responsibility, if different from patient

Emergency Contact Name

Emergency Contact Number

How Found ○ Phone Book ○ School ○ Ad ○ Previous Patient ○ Insurance Listing ○ Drive By ○ Other ○ Doctor

Referred By

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Caucasian ☐ Black or African American ☐ White ☐ Not Disclosed ☐ Native American ☐ Refuse to Specify ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Height ft ○ ft in In cm/m ○ cm ○ m

Weight ○ lbs ○ kg

Ethnicity

Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Language Preferences

○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

Complete Your Primary Care Physician

First Name | MI

Last Name

Clinic Name

Address | City

State | Zip

Phone Number

Complete Your Referring Physician

First Name | MI

Last Name

Clinic Name

Address | City

State | Zip

Phone Number

Complete Your Health History

Main Reason for Exam?

Last Exam Date? (MM/DD/YYYY)

When was your last health exam?

Enter past illnesses or injuries

Past Surgeries?

Please list all medications or provide a list to the doctor

Please list all eye drops you are currently using

Please list any reactions or sensitivities you have experienced

Please list any specific allergies

Complete Your Eye History

Glaucoma	○ Yes	◉ No	Infection of Lid	○ Yes	◉ No
Cataract	○ Yes	◉ No	Itching	○ Yes	◉ No
Macular Degeneration	○ Yes	◉ No	Mucous Discharge	○ Yes	◉ No
Retinal Detachment	○ Yes	◉ No	Drooping Eyelid	○ Yes	◉ No
Color Blindness	○ Yes	◉ No	Redness	○ Yes	◉ No
Headaches	○ Yes	◉ No	Sandy or Gritty Feeling	○ Yes	◉ No
Glare/Light Sensitivity	○ Yes	◉ No	Blurred Vision Distance	○ Yes	◉ No
Tired Eyes	○ Yes	◉ No	Blurred Vision Near	○ Yes	◉ No
Lazy Eyes	○ Yes	◉ No	Crossed Eyes	○ Yes	◉ No
Burning	○ Yes	◉ No	Distorted Vision (halos)	○ Yes	◉ No
Dryness	○ Yes	◉ No	Double Vision	○ Yes	◉ No
Excess Tearing/Watering	○ Yes	◉ No	Floaters or Spots	○ Yes	◉ No
Eye Pain or Soreness	○ Yes	◉ No	Fluctuating Vision	○ Yes	◉ No
Foreign Body Sensation	○ Yes	◉ No	Loss of Vision	○ Yes	◉ No
Loss of Side Vision	○ Yes	◉ No			

Complete Your General Health Condition

Fever	○ Yes	◉ No	Muscles/Bones/Joints	○ Yes	◉ No
Weight Loss	○ Yes	◉ No	Skin	○ Yes	◉ No
Other Symptoms	○ Yes	◉ No	Neurological (i.e. Multiple Sclerosis)	○ Yes	◉ No
Ears/Nose/Throat	○ Yes	◉ No	Anxiety or Depression	○ Yes	◉ No
Heart conditions (i.e. high blood pressure)	○ Yes	◉ No	Thyroid/Diabetes	○ Yes	◉ No
Respiratory (i.e. Asthma)	○ Yes	◉ No	Blood/Lymph (cholesterol)	○ Yes	◉ No
Gastrointestinal	○ Yes	◉ No	Allergic	○ Yes	◉ No
Kidney	○ Yes	◉ No			
Are you?	☐ Pregnant ☐ Nursing				

Complete Your Family History

Amblyopia (Lazy Eye)	○ Yes	◉ No	Cancer	○ Yes	◉ No
Blindness	○ Yes	◉ No	Diabetes	○ Yes	◉ No
Cataract(s)	○ Yes	◉ No	Heart Disease	○ Yes	◉ No
Color Blindness	○ Yes	◉ No	High Blood Pressure	○ Yes	◉ No
Glaucoma	○ Yes	◉ No	Kidney Disease	○ Yes	◉ No
Macular Degeneration	○ Yes	◉ No	Lupus	○ Yes	◉ No
Retinal Detachment	○ Yes	◉ No	Stroke	○ Yes	◉ No
Strabismus (i.e. Eye Turn)			Thyroid Disease		

	○ Yes	◉ No		○ Yes	◉ No
Arthritis	○ Yes	◉ No	Others	○ Yes	◉ No

Complete Your Spectacle Lens History

Do you use a computer? ○ Yes ◉ No

How many hours/day?

Distance from Computer?

Do you drive? ○ Yes ◉ No

Mileage to work each way?

Do you have glare problems? ○ Yes ◉ No

Do you have visual difficulty when driving? ○ Yes ◉ No

Do you have problems with night vision? ○ Yes ◉ No

Do you currently wear glasses? ○ Yes ◉ No Since?

Type of glasses? ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned? ○ SingleVision ○ Bifocals ○ Trifocals ○ Backup Glasses ○ Safety ○ Sports ○ Progressive

Have you had trouble with glasses in the past? ○ Yes ◉ No Reason:

Do you wear sunglasses? ○ Yes ◉ No

Are your sunglasses your current prescription? ○ Yes ◉ No

Special eyewear needs?

- ☐ Computer (special prescriptions, special anti-glare tints or coatings)
- ☐ Occupational (mechanics, plumbers, pilots)
- ☐ Safety Glasses (gardening, woodworking, welding)
- ☐ Sports/Hobbies (racquet sports, motorcycle)

Complete Your Contact Lens History

Do you currently wear contact lenses? ○ Yes ◉ No Since?

If not a contact lens wearer, are you interested in trying contact lenses at this time? ○ Yes ◉ No

Have you ever tried to wear contacts? ○ Yes ◉ No

If yes, what was the reason for stopping?

Type and brand of contacts?

Today's wearing time?

How many hours/day?

How many days/week?

Please rate the following on a scale of 1-10 with 1 being POOR and 10 being EXCELLENT.

Lens Comfort	Right		Left	
Distance Vision	Right		Left	
Near Vision	Right		Left	

What solutions do you use?

Disinfectant used?

Enzyme used?

Complete Your Social History

Current occupation

Years?

Employer Name

Do you use nutritional supplements (vitamins etc.)? ○ Yes ◉ No

Do you engage in regular exercise? ○ Yes ◉ No

Do you drink alcohol? If yes - how often? ◉ No ○ Occasional ○ 1 per day ○ 2-3/day ○ 4+/day

Do you smoke? If yes - how much/often ◉ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Smoking Status

○ Current every day smoker
○ Current some day smoker
○ Former smoker
○ Never smoker
○ Smoker, current status unknown
○ Unknown if ever smoked

Method of Tobacco Intake? ○ Smoking ○ Chewing

Do you use Illegal Drugs? ○ Yes ◉ No

List your hobbies

Thank you for completing the Welcome Form information, we will be able to provide you with the best evaluation of your health using this information. We look forward to seeing you soon!