PATIENT INFORMATION FORM

DATE: ______________________________

PLEASE PRINT

PATIENT INFORMATION

TITLE	NAME			
MISS MR. MRS. MS. OTHER________	LAST	FIRST		MI
MAILING ADDRESS	ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	HOME ( )	WORK ( )	CELLULAR ( )	EMAIL ADDRESS
BIRTH DATE / /	SEX ☐FEMALE ☐MALE	PATIENT SS# / /	OCCUPATION	INTERESTS/ACTIVITIES

PATIENT SIGNATURE (PARENT/GUARDIAN FOR PATIENT UNDER 18 YEARS OLD)____________________

INSURANCE INFORMATION

☐VSP ☐MES ☐EYEMED ☐____________________ ____________________

RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐DOMESTIC PARTNER ☐CHILD ☐OTHER__________

____________________ ____________________

EMERGENCY CONTACT

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME______________________________ RELATIONSHIP______________________________

HOME PHONE: ( ) WORK PHONE: ( ) CELL PHONE: ( )

Reason for visit:

____
____
____
____
____

Date of last eye exam: ______________________________

Eye Health History

Do you wear glasses?	☐ Yes	☐ No
If yes, how often?	☐ All day ☐ Driving ☐ Computer	☐Occasionally ☐ Reading ☐ TV/Movies
Do you wear contact lenses?	☐ Yes	☐ No
Type: ☐ Gas Perm ☐ Soft	Hours per day:__________	

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

☐ Dry Eyes	☐ Burning Eyes	☐ Discharge
☐ Floaters/Spots	☐ Eye Infection	☐ Migraine Headache
☐ Light Sensitive	☐ Glaucoma	☐ Blurred Distance Vision
☐ Red Eyes	☐ Loss of Vision	☐ Blurred Near Vision
☐ Watery Eyes	☐ Seeing Halos	☐ Other:_____
☐ Twitching Eyelid	☐ Headaches	
☐ Seeing Flashes	☐ Eye Injury	
☐ Itchy Eyes	☐ Double Vision	
☐ Eyestrain	☐ Poor Night Vision	

General Health History

Primary Physician's Name: Dr.____________________	Date of Last Visit: __________

List all medications you are taking, including eye drops:

____
____
____

List your allergies to medications and other substances:

____
____

Check appropriate boxes to indicate if you and/or your family members have any of these conditions:

Condition	Self	Family	Condition	Self	Family
AIDS/HIV	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	Lazy Eye	☐	☐
Asthma	☐	☐	Lupus	☐	☐
Blindness	☐	☐	Migraine Headaches	☐	☐
Cancer	☐	☐	Retinal Disease	☐	☐
Cataracts	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Thyroid Conditions	☐	☐
Eye Surgery	☐	☐	Turned Eye	☐	☐
Glaucoma	☐	☐	Other:_______		
Hay Fever	☐	☐			
Heart Disease	☐	☐			
Hepatitis:_____	☐	☐			

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

How did you hear about us? Walk-in VSP EyeMed Patient Referral ______________________ Online/Yelp Other______________