Patient Information

Today's Date _____

All payments are due on date of service.

Last Name_____

First _____M.I. _____

Date of Birth _____

Email Address _____

Cell Phone # _____

Home Phone#_____

I prefer to be contacted via: ❑ Phone ❑ Email

Employer (or School) _____

Occupation (or Grade) _____

Height _____ Ethnicity/Race_____

Weight_____ Preferred Language_____

What is the major purpose of this visit?

_____

_____

Do you have any problems with your current contact lenses or glasses? Please describe:

_____

_____

How did you hear about us?

_____

Patient Eye History

Date of Last Eye Exam _____

Where was it? _____

Do you currently wear glasses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

Please write your current contact lens brand and prescription if known:

Right eye: _____

Left eye: _____

Have you ever experienced, been diagnosed with, or been treated for any of the following?

❑ Dryness
❑ Redness
❑ Blurred Vision
❑ Sandy/Gritty Eyes
❑ Watery Eyes
❑ Cataracts
❑ Crossed Eye/Eye Turn
❑ Eye Infections
❑ Flashes of Light
❑ Glaucoma
❑ Iritis/Uveitis
❑ Macular Degeneration
❑ Trouble Seeing at Night
❑ Itching
❑ Burning
❑ Vision Fluctuations
❑ Light Sensitivity
❑ Tired Eyes/Fatigue
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Headaches
❑ Lazy Eye
❑ Retinal Detachment
❑ Other eye disorders:_____

_____

_____

❑ Eye Surgeries (describe):

_____

Office Use Only. Do Not Write below this Line. Please Turn Page Over and Complete Back Side.

Technician Initials: PT# ❑Copay Explained PA NOTES: Medical Covered or _____

CL (explained cost) Y or N Soft (S , T , MV, MF) RGP (S,T,MF)/Spec/ I&R Dil or DRI39

PreTesting: Pupils: RAPD + or - EOM: Full Range or Restricted Fields: Full or Restricted

IOP	TLab	Pach
R-	R-	R-
L-	L-	L-

VA Dist (SC) OD: OS: OU: N:

CL/GL (CC) OD: OS: OU: N:

CL: Brand

PrevRX OD: MR: OD: OD:

Or Lensom OS: OS: OS:

Dr's Recommendations:

Patient wants new glasses: YES or Possibly

Circle:SV (Dist, Comp, Near) /Digital PAL/Computer/Anti-Fatigue/Tint/Transition/ /HighIndex/Polarized/CrizalNoGlare/ Blue Light Blocking Lens/ Artificial Tears/ Plugs/ Fortifeye/Year Supply Contacts/ Other:

Follow up Visit in: ____day(s)____week(s) ___Month(s) ___year, For _____

Review of Systems

For insurance purposes, please check "yes" or "no" to each of the following – do not skip any.
Are you currently experiencing or being treated for any of the following problems?

	YES	NO
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
Endocrine		
Thyroid Circle: Hypo/Hyper/Other	❑	❑
Diabetes Circle: Type 1 Type 2	❑	❑
Ear, Nose, Mouth, Throat		
Seasonal Allergies	❑	❑
Sinus Congestion	❑	❑
Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Mouth/Dry Throat	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Cardiovascular		
High Cholesterol	❑	❑
High Blood Pressure	❑	❑
Heart Pain	❑	❑
Vascular Disease	❑	❑
Integumentary (Skin)	❑	❑
Constitutional		
Unusual weight losses/gains	❑	❑
Fevers	❑	❑
Fatigue	❑	❑
Gastrointestinal		
Chronic Diarrhea	❑	❑
Constipation	❑	❑
Genitourinary		
Genitals/Kidney/Bladder	❑	❑
Bones/Joints/Muscles		
Arthritis	❑	❑
Muscle Pain	❑	❑
Joint Pain	❑	❑
Lymphatic/Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Immunologic	❑	❑
Cancers	❑	❑
Psychiatric	❑	❑

***CURRENT MEDICATIONS**
List Medication and "why" you are taking in space below:

Medical History

Primary Care Physician _____

Please list any past and current medical problems or diagnoses: _____

Are you allergic to foods or medications? ❑ Yes ❑ No
Describe _____

Have you had any surgeries? ❑ Yes ❑ No
Describe: _____

Do you use cigarettes/tobacco, alcohol, or other drugs?
Describe/Frequency _____

Have you ever been a smoker? ❑ Yes ❑ No
If yes, when did you quit? _____

Family Medical/Eye History

Please check all that apply.

	Relationship/Side of Family
Diabetes	❑ _____
Glaucoma	❑ _____
Heart Disease	❑ _____
Blindness	❑ _____
Cataracts	❑ _____
Lazy Eye	❑ _____
Macular Degeneration	❑ _____
Corneal Problems	❑ _____
Retinal Problems	❑ _____
Other Eye Diseases	❑ _____

***List Pharmacy and Phone in Space Below:**

The mission of Origins Eye Clinic is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek out continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.