

WELCOME TO KISSEL VILLAGE EYE CARE

PATIENT INFORMATION—PLEASE PRINT

Last name	First Name	Initial	M/F	Birth Date	AGE
Home Address		City	State	Zip Code	
Home Phone	Work Phone		E-mail address		
Employer/School			Occupation/Grade		
Referred By/How did you hear about us?			Type of Insurance _____		
			Insurance ID# _____		SS# _____

PATIENT HISTORY—Please complete all information—circle yes or no.

- ◆ Primary reason for today's visit: _____
- ◆ Date of last exam: _____ By Dr.: _____ Age of current glasses: _____
- ◆ Name of primary physician: _____ Date of last medical exam: _____
- ◆ Have your eyes been dilated before (drops) ? Y/N If yes, when: _____
- ◆ Are you currently pregnant? Y/N If yes, how many weeks: _____
- ◆ Are you being treated for any medical condition? Y/N If yes, what: _____
- ◆ Are you taking any medications? Y/N If yes, which ones: _____

- ◆ Are you allergic to any medications? Y/N If yes, which ones: _____
- ◆ Do you have any other allergies? Y/N _____

PLEASE CHECK ANY/ALL CONDITIONS THAT APPLY:

	Self		Self	Relative		Self	Relative
Dryness	_____	Glaucoma	_____	_____	Thyroid Problem	_____	_____
Blurred Vision	_____	Cataracts	_____	_____	Asthma	_____	_____
Headaches	_____	Diabetes	_____	_____	Heart Disease	_____	_____
Double Vision	_____	Retinal Disease	_____	_____	Lung Disease	_____	_____
Eye Infection	_____	High Blood Pressure	_____	_____	Eye Disease	_____	_____
Eye Surgery	_____	HIV/Infectious Disease	_____	_____			

- ◆ Do you experience dryness, burning, itching, or gritty eyes? Y/N _____
- ◆ Do you work on a computer? Y/N If yes, how many hours? _____
- ◆ Do you experience eyestrain, headaches or dryness while using the computer? Y/N _____
- ◆ Are you interested in corrective eye surgery/ LASIK? Y/N _____
- ◆ List any sports and/or hobbies you participate in: _____
- ◆ Does your employer or your hobbies require safety eyewear? _____

CONTACT LENS INFORMATION

- ◆ Have you ever worn contact lenses? Y/N If yes, what type and when: _____
- ◆ Are you interested in new contact lenses? Y/N If yes, What type: _____

Cleaning System: _____ Have you ever had a reaction to drops or solutions: _____