Date:

ANNE ARUNDEL FAMILY EYE CARE

820 Bestgate Rd • Suite 1C • Annapolis MD 21401 • 410.266.0001 • fax 410.266.3988

PATIENT HISTORY

Name: Dr / Mr / Mrs / Ms _____
(FIRST) (MI) (LAST)

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ DOB: _____

Responsible Party: _____ SSN: _____

Insurance: _____

Patient Occupation: _____ Employer: _____

Last Eye Exam Date: _____ with Dr: _____

Whom may we thank for referring you? _____

What is your main reason for coming today? _____

_____

_____

This is your opportunity to tell us about all areas in which your vision is not serving you well:

Are there times when your vision (or present lens) isn't quite right? _____

_____

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

_____

Have you ever worn glasses? Y / N Do you wear glasses now? Y / N

If yes, O for distance only O for near only O wear them full time O for computer monitor O sports

Do you wear contacts at this time? Y / N What type? _____

Have you had problems wearing contacts? Y / N Describe: _____

Have you been told you cannot wear them? Y / N Are you interested in trying contacts? Y / N

Are you interested in Refractive Surgery? Y / N

Do you use a computer on your job? Y / N # of hours daily _____

Do you use a computer at home? Y / N # hours daily _____

What lenses do you wear? O none O glasses O bifocals O contacts

When computing, do your eyes get: O red O dry O sore

Do letters ever seem to swim? Y / N Does office lighting bother you? Y / N

Do reflections and glare bother you? Y / N Is it hard to proofread, or find errors? Y / N

Please fill in both sides of this form as completely as possible.

Do you experience any of the following discomforts at work or at home?

O headaches O eyestrain O get sleepy O letters blur as you read O eyes red or watery O lose your place often

O occasionally see double O pulling sensation near eyes O do you avoid certain tasks

Does it take more and more effort to see clearly as the day wears on? Y / N

Do you avoid reading after work, but read on weekends? Y / N How long can you read? _____

Do you "hunch" closer to your work as the day wears on? Y / N

Do street signs ever seem blurred as you drive home from work? Y / N

Is it ever difficult to bring print or objects to clear focus? Y / N When? _____

Recreation and Leisure

In what recreational activities do you participate? (check all that apply): O read O racquetball O tennis O golf

O baseball O basketball O swim O boating O sew O play cards O flying O lacrosse O musical instrument

Other recreationial activities: _____

Do you wear any special or protective eyewear for your sport? Y / N

Does your vision, or do your lenses, interfere with any activity? Y / N

What are doing to protect your eyes from ultraviolet exposure? _____

Do you currently wear glasses that have an anti-reflective coating? Y / N

Television: Is your viewing ever uncomfortable? Describe: _____

Do you recline while viewing? Y / N Do your lenses work for TV? Y / N Do you play video games? Y / N # hrs ____

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies:	O self	O family	Thyroid:	O self	O family	Dry eyes:	O self	O family
Respiratory disease:	O self	O family	Migrane or headaches:	O self	O family	Floaters/spots:	O self	O family
Cancer:	O self	O family	Head trauma:	O self	O family	Flashing lights:	O self	O family
Diabetes:	O self	O family	Lazy eye:	O self	O family	Retinal detachment:	O self	O family
Drug sensitive:	O self	O family	Turned eye:	O self	O family	Blindness:	O self	O family
Elevated cholesterol:	O self	O family	Color "blind":	O self	O family	Cataracts:	O self	O family
Heart problem:	O self	O family	Light sensitive:	O self	O family	Glaucoma:	O self	O family
High blood pressure:	O self	O family	Eyestrain:	O self	O family	Eye surgery or injury	_____	

Are you presetnly taking any medications? Y / N If so, please list and state for what purpose: _____

_____

Are you allergic to any medications? Y / N Is so, please list:: _____

Name of family doctor: _____ Date of last exam: _____

INSURANCE INFORMATION

VISION INSURANCE PLAN Patient's relationship to insured: O self O spouse O child O other

Name of Vision Plan: _____ Insured Name: _____ Insured DOB: _____

Policy Number: _____ Group number: _____ Member ID number: _____

Claims address: _____ Claims Phone number: _____

MAJOR MEDICAL INSURANCE Patient's relationship to insured: O self O spouse O child O other

Name of Vision Plan: _____ Insured Name: _____ Insured DOB: _____

Policy Number: _____ Group number: _____ Member ID number: _____

Claims address: _____ Claims Phone number: _____

Signature: _____ Date: _____ Dr's Initials/Date: _____