



Date: _____

ANNE ARUNDEL FAMILY EYE CARE

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, for distance only for near only wear them full time for computer monitor 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 (Lasik)? Y/N

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

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

What lenses do you wear? none glasses bifocals contacts

When computing, do your eyes get: red dry 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

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

headaches eyestrain get sleepy letters blur as you read eyes red or watery

lose your place often occasionally see double pulling sensation near eyes

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 into clear focus? Y/N When? _____

Recreation and Leisure

In what recreational activities do you participate? (check all that apply): read racquetball tennis golf baseball basketball swim boating sew play cards flying lacrosse musical instrument Other recreational 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 you 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:	<input type="checkbox"/> self <input type="checkbox"/> family	Thyroid:	<input type="checkbox"/> self <input type="checkbox"/> family	Dry Eyes:	<input type="checkbox"/> self <input type="checkbox"/> family
Respiratory disease:	<input type="checkbox"/> self <input type="checkbox"/> family	Migraine or headaches:	<input type="checkbox"/> self <input type="checkbox"/> family	Floaters / spots:	<input type="checkbox"/> self <input type="checkbox"/> family
Cancer:	<input type="checkbox"/> self <input type="checkbox"/> family	Head trauma:	<input type="checkbox"/> self <input type="checkbox"/> family	Flashing lights:	<input type="checkbox"/> self <input type="checkbox"/> family
Diabetes:	<input type="checkbox"/> self <input type="checkbox"/> family	Lazy eye:	<input type="checkbox"/> self <input type="checkbox"/> family	Retinal detachments:	<input type="checkbox"/> self <input type="checkbox"/> family
Drug sensitive:	<input type="checkbox"/> self <input type="checkbox"/> family	Turned eye:	<input type="checkbox"/> self <input type="checkbox"/> family	Blindness:	<input type="checkbox"/> self <input type="checkbox"/> family
Elevated cholesterol:	<input type="checkbox"/> self <input type="checkbox"/> family	Color "blind":	<input type="checkbox"/> self <input type="checkbox"/> family	Cataracts:	<input type="checkbox"/> self <input type="checkbox"/> family
Heart problem:	<input type="checkbox"/> self <input type="checkbox"/> family	Light sensitive:	<input type="checkbox"/> self <input type="checkbox"/> family	Glaucoma:	<input type="checkbox"/> self <input type="checkbox"/> family
High blood pressure:	<input type="checkbox"/> self <input type="checkbox"/> family	Macular Degeneration:	<input type="checkbox"/> self <input type="checkbox"/> family	Eye surgery or injury:	<input type="checkbox"/> self <input type="checkbox"/> family

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

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

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

INSURANCE INFORMATION

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

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

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

Claims Address: _____ Claims Phone Number: _____

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

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

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

Claims Address: _____ Claims Phone Number: _____

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