



Scott Drake, O.D. | Linda Drake, O.D.
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Welcome to our office.

Last Name _____ Today's Date _____
First Name _____ MI _____
Street _____
City _____ State _____ Zip _____
Home Phone _____ Cell _____
Work Phone _____
Employer (or School) _____
Occupation (or Grade) _____
Date of Birth _____ Age _____ Sex M F
Email Address _____
Spouse (or Parent) _____
Spouse's Employer (or Parent's) _____

What is your major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

Who may we thank for referring you to our office? _____
If not referred, how did you choose our office for your eyecare needs?

- Another Doctor Insurance List
- Saw Sign/Building Newspaper/Radio/TV
- Yellow Pages...Which directory? _____
- World Wide Web...Which website? _____
- Other _____

INSURANCE INFORMATION

Vision Insurance: _____

Subscriber Name: _____

Insurance Phone Number: _____

Subscriber Insurance Number: _____

(Usually Social Security Number)

Subscriber Birth Date: _____

Primary Medical Insurance: _____

Subscriber Insurance Number: _____

Do you participate in a flex spending account? Yes No

How will you settle your account today?

- Check Cash Credit Card

FAMILY MEDICAL/EYE HISTORY (CHECK ALL THAT APPLY)

Is there a family medical history of any of the following?

Relationship

- Blindness _____
- Cataracts _____
- Corneal Problems _____
- Glaucoma _____
- Lazy Eye _____
- Macular Degeneration _____
- Retinal Problems _____
- Diabetes _____
- Heart Disease _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

PATIENT MEDICAL HISTORY

Name of Family Physician _____

City, State _____

Date of Last Physical Check-Up _____

CURRENT MEDICATIONS (Rx or Over-the-Counter)

List name of medications including eye drops, vitamins and birth control pills _____

Allergies to medications? Yes No

Have you ever been diagnosed or treated for the following?

- Allergies Diabetes Nerves
- Asthma Heart Disease Thyroid
- Cancer High Blood Pressure
- Cholesterol Kidney
- Other _____

Are you a current smoker? Yes No

PATIENT EYE HISTORY

Date of last eye exam? _____

By whom? _____

Do you currently wear contact lenses? Yes No

What brand? _____

How often do you replace your contacts? _____

Solutions used? _____

Would you prefer colored contact lenses to change the color of your eyes? Yes No

Have you ever tried contact lenses? Yes No

Are you interested in trying contact lenses? Yes No

Are you pregnant at this time? Yes No

Are you interested in longer, darker lashes? Yes No

Do you...(Check box if your answer is yes)

- ...work at a computer? (_____ hours/day)
- ...sometimes experience dry or watery eyes?
- ...think you might benefit from thinner, lighter lenses?
- ...have an interest in a "test drive" of the latest contact lens design?
- ...spend time outdoors? (_____ hours/week)
- ...have prescription sunglasses?
- ...prefer not to wear glasses at times?
- ...want information on Laser Vision Correction surgery?
- ...have a history of eye surgery? (What type? _____)
- ...have more than 1 pair of current Rx glasses?
- ...have children? (_____, ages _____)
- ...have family members in need of eyecare?

If you wear bifocals, are you bothered by the lines or head tilting?

Yes No

If you wear contact lenses, are you satisfied with the vision and comfort?

Yes No

Have you ever been diagnosed or treated for the following?

- Cataracts Iritis/Uveitis
- Corneal Abrasion Lazy Eye
- Eye infection Macular Degeneration
- Eye injury Retinal Detachment
- Glaucoma Other eye disorders

Do you experience or have you ever experienced any of these?

- Blurry Vision Flash of light Sunlight sensitivity
- Burning Floaters/Spots Tearing
- Crossed eye Grittiness Fluctuating vision
- Double vision Headaches Itchiness
- Trouble seeing at night Mild, moderate or severe dryness
- Uncomfortable glasses Uncomfortable eyes

Hobbies:

- Golf Tennis Sewing
- Video Games Reading Hunting
- Other _____

Signature _____ Date _____