Welcome to Adamstown Eye Care, LLC

Patient Name _____ Date _____

Address _____ Sex: Male_____ Female_____ Age: _____

City / State / Zip _____ Birthdate _____

Home Phone: ( ) _____ S.S. # _____

Work Phone: ( ) _____ Employer _____

Parent / Responsible Party _____ Employer Address _____

(address *if different from above*) _____ _____

_____ Occupation _____

What brings you to our office today? (Check all that apply)

_____	General Checkup	_____	Glasses need replacement	_____	Other (list below)
_____	Blurred Vision	_____	To get contact lenses	_____	
_____	Headaches	_____	Contact lens problems	_____	

When was your last eye exam? _____ **Where?** _____

Have you ever had glasses? Yes _____ No _____ **Were they to see** Far____ Near____ or Both?___

Have you ever had contact lenses? Yes _____ No _____

If so, what type? Soft_____ Gas Permeable_____ Hard_____ Disposable_____ Extended Wear_____

Please list any special hobbies or activities you participate in _____

Please check if you are having any of the following eye problems:

_____	Red Eyes	_____	Eye Discharge	_____	Flashes of Light in Vision
_____	Itchy Eyes	_____	Eye Irritation	_____	Floaters in Vision
_____	Dry Eyes	_____	Eye Pain	_____	Double Vision
_____	Burning Eyes	_____	Loss of Vision	_____	Distorted Vision
_____	Watery Eyes	_____	Shadows in Vision	_____	Extreme Light Sensitivity

Please check any of the following items as they apply to you or to your family (blood relatives only)**:**

	YOURSELF		**FAMILY**			**YOURSELF**		**FAMILY**	
	Yes	No	Yes	No		Yes	No	Yes	No
Cataracts	____	____	____	____	Diabetes	____	____	____	____
Glaucoma	____	____	____	____	High Blood Pressure	____	____	____	____
Retinal Problems	____	____	____	____	Heart Disease	____	____	____	____
Eye Surgery	____	____	____	____	Circulatory Problems	____	____	____	____
Eye Injuries	____	____	____	____	Cancer	____	____	____	____
Eye Infections	____	____	____	____	Thyroid Disease	____	____	____	____
Blindness	____	____	____	____	Allergies	____	____	____	____
Lazy Eye	____	____	____	____	Respiratory Problems	____	____	____	____
Other Eye Problems (list below)					Arthritis	____	____	____	____
_____					Multiple Sclerosis	____	____	____	____

Please list any other health disorders so the doctor is aware of them: _____

Do you smoke or use tobacco? Yes_____ **No**_____ **Do you use alcohol? Yes**____ **No**____

Are you Pregnant? Yes_____ **No**_____ **Possibly**_____

Do you take Medications, Hormones, or Birth Control Pills? Yes_____ No_____ **If Yes, please list below:**

_____

What is the name of your family doctor? _____

If you have an Eye Health Insurance Plan, please list the Insurance Company _____

Are you Allergic to any Medications? Yes_____ No_____ **If Yes, please list:** _____

Have your eyes been dilated before? Yes_____ No_____ **If Yes, when:** _____

How did you hear about our office? _____

Thank you for assisting us in serving you