YOUR TWO eyes OPTOMETRY

Date _____

Name _____ PREFERRED NAME _____

☐DR. ☐MR. ☐MRS. ☐MS. Date of Birth _____ SS# (LAST 4 DIGITS) _____

Pronouns: ☐HE/HIM/HIS ☐SHE/HER/HERS ☐THEY/THEM/THEIRS ☐OTHER _____

Occupation _____

Contact Information HAS YOUR CONTACT INFORMATION CHANGED SINCE WE LAST SAW YOU? ☐NO ☐YES, PLEASE UPDATE:

Address _____
City _____ Zip Code _____

Telephone: MOBILE # _____ Can we text you? ☐YES ☐NO
HOME # _____ WORK # _____

Email _____

Preferred Language_____ Race _____

Emergency Contact / Relationship _____ Phone _____
Parent/Guardian (If Applicable) _____ Phone_____

Vision Insurance If available, please bring insurance card to your appointment

☐ VISION SERVICE PLAN (VSP) ☐ OTHER _____ ID NUMBER (if available)_____
If patient is not the primary member on insurance, please provide:
INSURED 'S NAME _____ DOB _____ SS# (LAST 4 DIGITS) _____

If not previously seen at Your Two Eyes Optometry, please provide:

Year of Last Vision Exam _____
Doctor/Practice _____ Phone_____
Address _____

I GRANT PERMISSION TO COLLECT RELEVANT MEDICAL RECORDS FROM MY FORMER EYE CARE PRACTITIONER WHEN DONE IN ACCORDANCE WITH HIPAA PRIVACY RULES AND IN THE BEST INTEREST OF MY VISION AND HEALTH.
PATIENT INITIALS _____

Health Insurance Please bring insurance card to your appointment

CARRIER_____ ID NUMBER _____
If patient is not the primary on insurance, please provide:
INSURED 'S NAME _____ DOB _____ SS# (LAST 4 DIGITS) _____

Year of Last Medical Exam _____
Doctor /Practice _____ Phone _____
Address _____

I GRANT PERMISSION TO DISCLOSE OR COLLECT RELEVANT MEDICAL INFORMATION WITH MY NAMED HEALTHCARE PROVIDER WHEN DONE IN ACCORDANCE WITH HIPAA PRIVACY RULES AND IN THE BEST INTEREST OF MY HEALTH AND WELL BEING.
PATIENT INITIALS _____

Medical History

Do you have any allergies to medications? ☐NO ☐YES: _____

List any medications you take and what conditions you take them for (including eyedrops, oral contraceptives, pain medication, over the counter medications, home remedies, vitamins):

_____

_____

_____

_____

Check any of the following that you have had: ☐ NO TO ALL

☐ CROSSED EYES	☐ PROMINENT/BULGING EYES	☐ RETINAL DETACHMENT	☐ CATARACTS
☐ LAZY EYE	☐ DRY EYE	☐ MACULAR DEGENERATION	☐ EYE INJURY
☐ DROOPING EYELID	☐ GLAUCOMA	☐ EYE INFECTIONS	☐ EYE SURGERY

Describe further:

_____

_____

List all major surgeries and/or hospitalizations you have had and when:

_____

_____

Spectacles History

Do you wear glasses? ☐NO ☐YES: If yes, how old is your primary pair? _____

Do you use them: ☐FULL TIME ☐PART TIME

Types of glasses you use:

☐ FAR / DISTANCE	☐ BIFOCAL / TRIFOCAL / PROGRESSIVE	☐ SPORTS
☐ CLOSE / READING	☐ COMPUTER / OFFICE	☐ OCCUPATIONAL / SAFETY
☐ SUN Are they prescription sunglasses? ☐Yes		☐BACK UP / EMERGENCY

Contact Lens History

Do you currently wear contacts? ☐NO ☐YES: Type: ☐SOFT ☐RIGID ☐SCLERAL ☐EXTENDED WEAR ☐CRT / OK

Brand: _____ Solution Type: _____

HOURS/DAY _____ DAYS/WEEK _____ Do you use artificial tears: ☐NO ☐YES: Type _____

Rate the following on a scale of 1 to 10 : LENS COMFORT_____ DISTANCE VISION_____ NEAR VISION_____

At what point of the day do your contacts get uncomfortable? _____

Review of Systems

Do you currently, or have you ever routinely had any problems in the following areas? ☐ NO TO ALL

EYES
loss of vision..... ☐Yes
blurred vision..... ☐Yes
distorted vision/halos..... ☐Yes
loss of side vision..... ☐Yes
double vision..... ☐Yes
dryness..... ☐Yes
mucous discharge..... ☐Yes
redness..... ☐Yes
sandy or gritty feeling..... ☐Yes
itching..... ☐Yes
burning..... ☐Yes
foreign body sensation..... ☐Yes
excess tearing/watering..... ☐Yes
glare/light sensitivity..... ☐Yes
eye pain or soreness..... ☐Yes
chronic infection, eye or lid... ☐Yes
styes or chalazion..... ☐Yes
flashes/floaters in vision..... ☐Yes
tired eyes..... ☐Yes

CONSTITUTIONAL
fever, weight loss/gain..... ☐Yes
Integumentary (skin)..... ☐Yes
Neurological..... ☐Yes
headaches..... ☐Yes
migraines..... ☐Yes
seizures..... ☐Yes

ENDOCRINE
thyroid/other glands..... ☐Yes
reproductive..... ☐Yes
pregnant currently..... ☐Yes
If yes, how many weeks _____

EARS, NOSE, MOUTH, THROAT
allergies/hay fever..... ☐Yes
sinus congestion..... ☐Yes
runny nose..... ☐Yes
post-nasal drip..... ☐Yes
chronic cough..... ☐Yes
dry throat/mouth..... ☐Yes

RESPIRATORY
asthma..... ☐Yes
chronic bronchitis..... ☐Yes
sleep apnea..... ☐Yes
emphysema..... ☐Yes

VASCULAR/CARDIOVASCULAR
diabetes..... ☐Yes
heart pain..... ☐Yes
high blood pressure..... ☐Yes
vascular disease..... ☐Yes
high cholesterol..... ☐Yes
heart attack ..... ☐Yes
stroke ..... ☐Yes

BONES/JOINTS/MUSCLES
rheumatoid arthritis..... ☐Yes
muscle pain..... ☐Yes
joint pain..... ☐Yes

LYMPHATIC/HEMATOLOGIC
anemia..... ☐Yes
bleeding problems..... ☐Yes

ALLERGIES..... ☐Yes
Type: _____

AUTO-IMMUNE..... ☐Yes
Type: _____

PSYCHIATRIC..... ☐Yes
Type: _____

GASTROINTESTINAL
Inflammatory Bowel Disease.. ☐Yes
diarrhea..... ☐Yes
constipation..... ☐Yes
genitals/kidney/bladder..... ☐Yes

OTHER:
_____
_____

Family History

Family (parents, grandparents, siblings, children; living or deceased) with following conditions: ☐ NO TO ALL

		IF YES, WHICH RELATIVES?
blindness	☐Yes	_____
cataract (BEFORE AGE 65).....	☐Yes	_____
crossed eyes	☐Yes	_____
glaucoma	☐Yes	_____
macular degeneration ...	☐Yes	_____
retinal detachment	☐Yes	_____
arthritis	☐Yes	_____
auto immune disease	☐Yes	_____
cancer	☐Yes	RELATION/TYPE _____
diabetes	☐Yes	_____
heart disease	☐Yes	_____
high blood pressure	☐Yes	_____
high cholesterol	☐Yes	_____
thyroid disease	☐Yes	_____
stroke	☐Yes	_____
other	☐Yes	_____

Social History [THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL]

☐ I WOULD PREFER TO DISCUSS MY INFORMATION DIRECTLY WITH MY DOCTOR

Gender assigned at birth: ☐ MALE ☐ FEMALE

Do you drive? ☐NO ☐YES
If yes, do you have visual difficulty when driving? Please describe: _____

Do you use tobacco products? ☐NO ☐YES
Type/amount/number of years? _____

Do you drink alcohol? ☐NO ☐YES
Type/amount/number of years? _____

Do you use recreational drugs? ☐NO ☐YES
Type/amount/number of years? _____

Do you drink caffeinated drinks? ☐NO ☐YES
What kind, volume and how often? _____

Do you drink sweet drinks? ☐NO ☐YES
What kind, volume and how often? _____

Do you engage in regular exercise? ☐NO ☐YES
What kind(s)? how often? Hours per week? _____

What are your hobbies/ interests/activites:
INDOOR_____ OUTDOOR _____

Are you a student? ☐YES: What grade level: _____ FAVORITE SUBJECT_____
SCHOOL _____ LEAST FAVORITE SUBJECT_____

Have you ever been exposed to or infected by: ☐ NO TO ALL

☐ CHICKEN POX / SHINGLES	☐ HERPES	☐CHLAMYDIA	☐ SYPHILIS	☐ HIV
☐ FUNGAL INFECTION	☐ SARS/COVID	☐ GONORRHEA	☐ HEPATITIS	☐MRSA

Patient Signature

Upon completion of this form and upon update/review:

PATIENT SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____

PATIENT SIGNATURE _____ DATE _____