

# Patient Intake Form

Date \_\_\_\_\_

First \_\_\_\_\_ Last \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Last four of Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Pharmacy & Address \_\_\_\_\_

Occupation \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

## How did you hear about us?

Walk-in: \_\_\_\_\_

WEB: \_\_\_\_\_

Referred by: \_\_\_\_\_

## Demographics

### Preferred Language(circle one)

English  
Spanish  
Other \_\_\_\_\_

### Race (circle one)

American Indian/Alaska Native  
Asian  
Black or African American  
Caucasian  
Native Hawaiian /Other Pacific Islander

### Ethnicity(circle one)

Non-Hispanic  
Hispanic or Latino

1. Do you currently wear contact lenses? If yes, What Brand? \_\_\_\_\_

2. Are you satisfied with the vision and comfort of your contact lenses? \_\_\_\_\_

3. Are you interested in clear contacts or colored? \_\_\_\_\_

## Ocular History

Blurry Vision _____	Itchiness _____	Floaters/Spots _____
Burning _____	Lazy Eye _____	Glaucoma _____
Eye Infections _____	Occasional Dryness _____	Iritis/Uveitis _____
Cataracts _____	Retinal Detachment _____	Headaches _____
Double Vision _____	Sunlight Sensitivity _____	Other Eye Disorders _____
Eye Injury _____	Tearing _____	Flashes of Light _____
Trouble Seeing at night _____		

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## Medical History

Allergies \_\_\_\_\_ Ears/Nose/Throat \_\_\_\_\_  
Eczema/Rashes \_\_\_\_\_ Fevers \_\_\_\_\_  
High Blood Pressure \_\_\_\_\_ Kidney \_\_\_\_\_  
Blood/Lymph \_\_\_\_\_ Cancer \_\_\_\_\_  
Diabetes \_\_\_\_\_ Neurological \_\_\_\_\_  
Respiratory \_\_\_\_\_ Bronchitis \_\_\_\_\_  
Arthritis \_\_\_\_\_ Cholesterol \_\_\_\_\_  
Digestive \_\_\_\_\_ Psychological \_\_\_\_\_

## Family Eye History

	Mother's side	Father's side
Blindness	_____	_____
Cataracts	_____	_____
Dry Eye	_____	_____
Diabetes	_____	_____
Glaucoma	_____	_____
Lazy Eye	_____	_____
Macular Degeneration	_____	_____

## List Your Medications:

Medication:	Dosage:	Medication:	Dosage:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Allergies to Medications? (circle one)  
Yes / No
- If so, what medications? \_\_\_\_\_
- Have you had any eye surgeries? (circle one)  
Yes / No
- Surgery type? \_\_\_\_\_
- Do you use cigarettes/tobacco, alcohol and/or other substances? Yes / No (circle one)  
Alcohol / Cigarettes or Ground Tobacco / Illicit Drugs: \_\_\_\_\_