Anthony D. Bailey OD PC

Welcome to our office

Today's Date _____
Last _____ First _____ MI _____
Street _____
City _____ State _____ Zip _____
Home Phone _____
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 _____

PATIENT EYE HISTORY

Date of last eye exam? _____
By whom? _____
Do you currently wear contact lenses? ☐ Yes ☐ No
What kind? _____
How often do you replace your contacts? _____
Solutions used? _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____
Have you ever tried contact lenses? ☐ Yes ☐ No
Are you interested in trying contact lenses? ☐ Yes ☐ No
Do you want information on refractive surgery? ☐ Yes ☐ No

Do you...(Check box if your answer is yes)
☐ ...work at a computer?
☐ ...sometimes experience dry 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? (How much? _____ hours/week)
☐ ...have prescription sunglasses?
☐ ...prefer not to wear glasses at times?
☐ ...want information on Laser Vision Correction surgery?
☐ ...have interest in a non-surgical approach to vision correction?
☐ ...have more than 1 pair of current Rx glasses?
☐ ...have children?
☐ ...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 ☐ Severe dryness
☐ Double vision ☐ Headaches ☐ Itchiness
☐ Trouble seeing at night ☐ Uncomfortable glasses

Signature _____ Date _____