20 | TWENTY
EYECARE

Patient Information

Today's Date:___/_____/_______
Name: (*last*)___________________________(*first*)________________________(*middle*)_____________
Date of Birth:___________________ Age:__________ SSN:______________________ Sex: ___M / F____
Street:____
City:____________________________ State:_____________ Zip:___________________________________
Cell Phone: __________________Home Phone:__________________ Work Phone:______________________
Email Address: ____________________________ **Preferred contact?: Cell / Home / Work / Email**
Employer (or School) __________________________ Occupation (or Grade): ______________________
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated
Race: ☐American Indian ☐Asian ☐African American ☐Caucasian ☐Hispanic ☐Native Hawaiian ☐Other
Spouse/Parent/Partner (*please circle*): ____
Spouse/Parent/Partner Work: ____

Insurance Information

-Please note, insurance generally does NOT cover the Contact Lens Evaluation-
Vision Insurance: _________________________ Subscriber Name: __________________________________
Subscriber Ins. ID: ____________________________ Subscriber Birth Date: ______________________
Primary Medical Ins: _______________________ Subscriber Name: __________________________________
Subscriber Ins. ID: ____________________________ Subscriber Birth Date: _______________________
Subscriber Address: ____
Subscriber City: _______________________ State: _______________ Zip: ___________________________

Very Important! New Patients Only
Who may we thank for referring you to our office? Name of friend or relative:___________________
How did you choose our office if not from friend or relative?
☐ Doctor Referral: ___________________________ ☐ Insurance List ☐Saw Sign/Building
☐ Web Page: __________________________ ☐ Other: ____

Please tell us why you're here today:____
Previous Eye Doctor: ______________________________ Date of last exam: _________________________
Do you currently wear glasses? ___Yes ___No Are you happy with the vision of your glasses? ___Yes ___No
Do you currently wear contact lenses? ___Yes ___No ___Interested in them?
Do you sleep in your contacts? ___Yes (____days/week) ___ No
Brand:________________________________ Solutions used:_______________________________________
Are you satisfied with the vision and comfort of your contact lenses? ___Yes ___No

Lifestyle Questions: Do you…(check if your answer is yes)
____Work at a computer?
___ Want information on LASIK or PRK?
___ Have interest in a "test drive" of the latest contact lens?
___ Have family members in need of eyecare?
___ Spend time outdoors? If yes, how many hours per week? ___________

PERSONAL Ocular History Please check all of the following eye conditions that apply to you:

___ Blurred vision ___ Loss of vision ___ Trouble seeing at night ___ Headaches
___ Sunlight sensitivity ___ Burning ___ Itching ___ Redness
___ Grittiness ___ Dryness ___ Eye Infections ___ Eye Injury
___ Floaters or Spots ___ Flashes of light ___ Lazy Eye/Amblyopia ___ Crossed Eye
___ Cataracts ___ Glaucoma ___ Macular Degeneration
___ LASIK/PRK Surgery ___ Cataract Surgery ___ Retinal Detachment

PERSONAL Medical History Please check all of the following medical conditions that apply to you:

__Blood Pressure: __High __Low __Asthma __Arthritis __Respiratory/Lung
__Cholesterol, elevated __Headaches __Migraines __Brain Injury
__Diabetes: __Type 1 __ Type 2 __Hypothyroidism __Seizures __Stroke
__Integumentory (skin) __Fatigue __ Unusual weight loss/gain

__Allergies:________________________________ __Blood/Lymph disorders:______________________________
__Cancers/tumors:__________________________ __Neuro-developmental disorders:______________________
__Heart/vascular disorders:_________________ __Psychiatric disorders:________________________________
__Kidney disorders:________________________ __Liver disorders:_____________________________________
__Skin disorders:___________________________ __Digestive disorders:_________________________________

Have you had any major injuries, hospitalizations or surgeries?____
Do you currently use cigarette/tobacco products? ___Every day use ___Some day use ___Former use ___No
Do you drink alcohol? ___Yes ___No
Do you use recreational drugs? ___Yes ___No
Are you currently: ___Pregnant (# of weeks____) ___Nursing ___Neither

Do you currently have a primary medical physician? ___Yes ___No
Please list name of physician___________________________ Date of last check up/physical_________________

List of all your current medications: *(RX or over the counter, including eye drops, birth control pills, & vitamins)*

Medication	**Use/Reason Prescribed**

Allergies to medications? ____

FAMILY Medical History Please check the conditions that apply to your family. Please specify which family member, and if they are on your mother's/maternal side (M) or father's/paternal side (P)

___ Blindness:________________________________ ___ Cataracts:_________________________________
___ Macular Degeneration:_____________________ ___ Glaucoma: _________________________________
___ Retinal Disease:___________________________ ___ Lazy Eye/Amblyopia:_________________________
___ Heart Disease:____________________________ ___ Diabetes:__________________________________
___ Cancers/Tumors:__________________________ ___ High Blood Pressure:_________________________
___ Arthritis:_________________________________ ___ Asthma:___________________________________
___ Thyroid Disease: __________________________ ___ Autoimmune Disorder:________________________