INTAKE FORM

Date: / / Name: Birthdate: / /
Street Address: City Zip:
Cell Phone: Home Phone: Work Phone:
E-mail:
Race: African/African American Asian/Asian American Caucasian/European
Native American/Alaskan Native Hawaiian/Pacific Islander Other Race:
Preferred Language: English / Spanish / Other: Hispanic/Latino Ethnicity: YES / NO
Employer/Occupation:
Vision Insurance? YES / NO Provider:
Health Insurance? YES / NO Provider: Medicare? YES / NO
Purpose of today's visit:

Medical/Ocular History

Date of Last Eye Exam: / / Place:
Name of your Family Doctor:
Are you pregnant or nursing? NO / YES

Medications you take (include oral contraceptives, aspirin, over-the-counter, and supplements:

Allergies to Medication? NO / YES

List major injuries, surgeries, and/or hospitalizations you have had:

Circle and Explain any of the following that you have had:

Diabetes		Glaucoma	
Lazy Eye		Cataracts	
Eye Pain		Retinal Disease	
Eye Infections		Eye Injury or Surgery	
Headaches		Double Vision	

Do you wear glasses? NO / YES Do you wear contact lenses? NO / YES
Contact lens type/brand: Lens solution:
Would you like to try contacts? NO / YES Do you want COLOR contacts? NO / YES
(Color not available for all prescriptions)

Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

	No	Yes	Unsure	Relationship
Blindness	( )	( )	( )	
Cataract	( )	( )	( )	
Glaucoma	( )	( )	( )	
Macular Degeneration	( )	( )	( )	
Retinal Detachment/Disease	( )	( )	( )	
Cancer	( )	( )	( )	
Diabetes	( )	( )	( )	
Heart Disease	( )	( )	( )	
High Blood Pressure	( )	( )	( )	
Other				

Social History

Do you smoke? NO / YES Are you a former smoker? NO / YES
Do you participate in sports that require eye protection? NO / YES
Discuss any additional Social History information directly with the doctor.

W D U F S T B M R