Date of Exam_____

Advanced Eye of Marietta

Patient Information

Last Name _____

First Name _____

Middle Initial ____ Title _____ Suffix ____

Nick Name _____

Address _____

City _____

State _____ Zip Code _____

Please Indicate Preferred Number

Home Phone _____ ☐

Work Phone _____ ☐

Cell Phone _____ ☐

May We Text You? *Yes* ☐ *No* ☐

Email _____

Gender M☐ F☐ Date of Birth _____

Social Security# _____

Marital Status Single ☐ Married ☐ Other ☐

Employment Status FT ☐ PT ☐ Other ☐

Student Status FT ☐ PT ☐ N/A ☐

Employer _____

Occupation _____

Preferred Language _____

Ethnicity _____

How would you prefer us to contact you?

Email ☐ Postal ☐ Telephone ☐ Text ☐

How did you learn of our Practice? (Please Circle)

Family Friend Doctor Insurance Plan Internet Other

Is there someone we may thank for referring you to our office? If yes, whom? _____

Have you visited our website? *Yes* *No*

Insurance Information

Vision Insurance _____

Policy Holder's Name _____

Member ID or SS _____

Member's Date of Birth _____

Relationship to Patient _____

Medical Insurance _____

Policy Holder's Name _____

Member ID or SS _____

Member's Date of Birth _____

Relationship to Patient _____

Vision History

Primary Reason for Today's Visit

Routine Eye Exam ☐ Eye Disease or Condition ☐

Other: _____

Blurry Vision: *Up Close* *Far Away* *Double Vision*

Last Eye Exam: (Estimated Date) _____

Do you currently wear glasses? *Yes* *No*

If so, how often do you wear them? _____

Strength of Readers (If Applicable) _____

Do you currently wear contact lenses? *Yes* *No*

Brand _____ Hours worn per day

Power of Contacts: Right: _____ Left: _____

If not, are you interested in contact lenses *Yes* *No*

Have your worn contact lenses before? *Yes* *No*

Are you interested in Refractive Surgery? ***(LASIK)***

Yes *No*

Allergies and Medications

List All Current Medications and the Condition(s) they are for, including eye drops:

_____

_____

_____

_____

_____

List Any Allergies Including Food, Environmental or Allergies to Medication:

_____

_____

_____

Please List Past Eye Surgeries:

_____

_____

Personal and Family History

	Yourself	Family	Which Family Member
Anxiety	☐	☐	_____
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Cancer	☐	☐	_____
Cataracts	☐	☐	_____
Diabetes	☐	☐	_____
Dry Eyes	☐	☐	_____
Eye Injury	☐	☐	_____
Eye Surgery	☐	☐	_____
Flashes	☐	☐	_____
Floaters or Spots in your Vision	☐	☐	_____
Glaucoma	☐	☐	_____
Halos/Starbursts	☐	☐	_____
Double Vision	☐	☐	_____
Headaches	☐	☐	_____
Head Injury	☐	☐	_____
Head Surgery	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Itchy Eyes	☐	☐	_____
Lazy/Crossed Eyes	☐	☐	_____
Liver Problems	☐	☐	_____
Lupus	☐	☐	_____
Macular Degeneration	☐	☐	_____
Migraines	☐	☐	_____
Multiple Sclerosis	☐	☐	_____
Neck Injury/Surgery	☐	☐	_____
Ocular Migraines	☐	☐	_____
Retinal Disease	☐	☐	_____
Sinus Condition or Problems	☐	☐	_____
Sjrogen's	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Problems	☐	☐	_____
Vertigo	☐	☐	_____
Vision Therapy	☐	☐	_____