WELCOME TO I CARE OPTICAL

Patient Name:_____ Date of Birth_____ Today's Date_____

Address: _____ Sex M F Social Security # _____

City/Zip: _____ Employer:_____

Primary Phone: _____ Occupation: _____

Secondary Phone _____Email Address: _____

How did you here about our clinic? For whom may we thank? _____

Primary Insurance Carrier (Your insurance)		**Secondary Insurance Carrier (Your Spouse)**	
Insurance Name		Insurance Name	
Insured Name		Insured Name	
ID #		ID #	
Member's DOB		Spouse's DOB	

Relation to insured: ❍ Self ❍ Spouse ❍ Dependant

Purpose of Visit (blurry distance or near vision, update glasses or contact lenses, lost or broken glasses, etc…)

_____

List any allergies to medicines: _____

List any medications you take (including birth control pills, OTC products, vitamins, aspirin, etc.,)_____

_____

Personal/Family History: Do you or any family member have or had any of the following?

S: Self, F: Family, please check (√). Please also state for how long you have had the disease.

S	**F**		**S**	**F**	
		Glaucoma			Sudden Loss of Vision/Blindness
		Diabetic retinopathy			Lazy eye/eye turn
		Cataracts, Cataract Surgery			Eye Surgery
		Macular Degeneration			Eye exercises, Vision Therapy
		Iritis/Uveitis			Floaters, spots
		Retinal Detachment/Disease			Flashes of light
		Double Vision			Other eye problems:

S	**F**		**S**	**F**	
		Headache, Migraines or Seizures			Heart/Vascular Diseases
		Thyroid Disease			Arthritis/ Rheumatoid Arthritis
		Diabetes			Bleeding Problems
		High Blood Pressure			HIV positive
		Asthma, Bronchitis			Depression
		Allergies			Gastro-Intestinal Problems:
		Women, are you pregnant? Nursing?			Other systemic problems:

Social History (If you do not want to give a written response, please discuss with your optometrist.)

Do you drive? Yes No If yes, do you have difficulty with vision while driving? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

What type of hobbies or sport activities do you do?_____

Are you satisfied with your current pair of glasses? Yes or No or N/A

If no, what would you like to change about them?_____

How many hours are you on the computer per day? _____

Do you wear contact lenses? Yes No What type? Soft/rigid. What brand? _____

If you wear disposable lenses, how often do you throw them away? _____

How often do you sleep in your contacts? _____ What CL solution do you use? _____

Have you ever had refractive laser eye surgery? Yes No If no, are you interested? Yes No

Signature _____**Date** _____