Michael P. Anastasio, OD   Robert W. Banglmaier, OD   Kyle S. Benner, OD   Steven A. Goldstein, OD
Timothy A. Kearins, OD   Sian E. Liem, OD   Katherine D. Nickerson, OD   Francis H. Robbins, OD

Welcome!

The information you provide below is part of your medical record, and will be held in strict confidence. PLEASE PRINT.

Patient Information

Circle one: Mr. Mrs. Ms. Miss Dr. Rev.

Last name ____________________________ Suffix_______ First name __________________________ MI_______

Date of birth ________________________ Gender: M F Social Security number __________________________

Mailing address____

City ____ State ____________ ZIP Code __________________

Telephones: Home __________________ Work ______________________Mobile__________________________

Employer______________________________________ Occupation_______________________________________

E-mail ____ Is this your first visit with us? Yes No

If yes, who referred you? ____

Emergency contact ____ Telephone _____________________________

Race: (circle one)

Asian
American Indian/Alaska Native
Black or African American
Native Hawaiian/Other Pacific Islander
White
Decline to answer

Ethnicity: (circle one)

Latino/Hispanic
Unknown
Not Hispanic or Latino
Decline to answer

What is the primary language spoken at home? _____________________________________

Are you hard-of-hearing? Yes No Are you deaf? Yes No

Responsible Party (*If other than the patient, please complete the following.)*

Circle one: Mr. Mrs. Ms. Miss Dr. Rev.

Last name ____________________________ Suffix_______ First name __________________________ MI_______

What is the patient's relationship to the responsible party? Spouse Child

Date of birth ________________________ Gender: M F Social Security number __________________________

Mailing address____

City ____ State ____________ ZIP Code __________________

Telephones: Home __________________ Work ______________________Mobile__________________________

Professional fees for all services are payable at the time services are rendered. Fifty percent of fees for contact lenses and eyeglasses are payable when they are ordered, with the balance due when they are dispensed.

Please sign below that you have completed the above information to the best of your knowledge.

Signature____ Date ___________________________

Please Continue on the Other Side.

Patient History

Medical Information

Please check any medical conditions that apply to you or your immediate family:

Self	Family		Self	Family		Self	Family		Self	Family	
☐	☐	Arthritis	☐	☐	Depression	☐	☐	Heart condition	☐	☐	Pacemaker
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Thyroid disease
☐	☐	Anxiety	☐	☐	Epilepsy	☐	☐	Kidney disease	☐	☐	Ulcerative colitis
☐	☐	Cancer	☐	☐	Fibromyalgia	☐	☐	Lung disease	☐	☐	Other:
☐	☐	COPD	☐	☐	Hay fever	☐	☐	Migraines			____________________

Who is your primary care physician? ____

When was your last physical exam? ____

List the medications (and their dosages) that you currently take. Attach a list if you need more space.

____

____

When was your last eye exam? ____

Who was your previous eye doctor? ____

Do you have any allergies to medications? ____

Other allergies? ____

Do you drive? Yes No

Do you use tobacco? Yes No If yes, type and amount? __________________________________

Do you use drugs? Yes No If yes, type and amount? __________________________________

Do you drink alcohol? Yes No If yes, type and amount? __________________________________

What are your hobbies? ____

Do you use a computer? Yes No If yes, how many hours a day? ______________________________

Do you work or participate in any sports where there is an eye hazard? Yes No

Ocular Information

Please check any ocular conditions that apply to you or your immediate family:

Self	Family		Self	Family		Self	Family		Self	Family	
☐	☐	Burning eyes	☐	☐	Dry eyes	☐	☐	Flashes	☐	☐	Itchy eyes
☐	☐	Cataracts	☐	☐	Eye injury	☐	☐	Floaters/Spots	☐	☐	Keratoconus
☐	☐	Crossed eyes	☐	☐	Eye pain/soreness	☐	☐	Glaucoma	☐	☐	Light sensitivity
☐	☐	Discharge	☐	☐	Eye strain	☐	☐	Headache	☐	☐	Macular degeneration
☐	☐	Double vision	☐	☐	Eye surgery: ____________________________ (Procedure and date)				☐	☐	Watery eyes