

Welcome To Main Street Optometry

Today's Date _____

PERSONAL INFORMATION				CONTACT INFORMATION			
				Home Phone: _____ Work Phone: _____ Cell Phone: _____ *Email: _____			
LAST NAME	FIRST NAME	MI					
ADDRESS	CITY	STATE	ZIP				
BIRTHDAY	AGE			What is the best way for us to reach you? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Email <small>*Please enter your e-mail address if you would like to receive special offers and product information via electronic mail. You can unsubscribe from e-mail communications you receive from us at anytime. The mailing list is private and will not be sold.</small>			
INSURANCE INFORMATION				Do you participate in a Flex Spending Account <input type="checkbox"/> Yes <input type="checkbox"/> No Are you interested in applying for Care Credit <input type="checkbox"/> Yes <input type="checkbox"/> No How do you plan to settle your account today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Do you have an AARP Card? <input type="checkbox"/> Yes <input type="checkbox"/> No			
VISION INSURANCE		SUBSCRIBER'S NAME					
SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S EMPLOYER					
MEDICAL INSURANCE		SUBSCRIBER'S NAME					
SUBSCRIBER'S SSN	SUBSCRIBER'S DOB	SUBSCRIBER'S EMPLOYER					
HEALTH HISTORY				LIFESTYLE QUESTIONS			
Date of Last Physical _____		Name of Physician _____		➤ Which of the following visual demands do you encounter on a regular basis? <input type="checkbox"/> Artificial lighting <input type="checkbox"/> Computer work <input type="checkbox"/> Reading <input type="checkbox"/> Night Driving <input type="checkbox"/> Close-up work <input type="checkbox"/> Other _____			
Do You Currently Have Or Had Any Of The Following Conditions? <input type="checkbox"/> Diabetes <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Cancer <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke/Neurological <input type="checkbox"/> Kidney Problems <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Cardiovascular Problems <input type="checkbox"/> Skin Disorders <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Blood Clot/Bleeding <input type="checkbox"/> Are You Pregnant? <input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> Sickle Cell/Anemia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Other (Please Explain) _____				➤ Do you participate in any of the following hobbies or activities? <input type="checkbox"/> Golf <input type="checkbox"/> Running <input type="checkbox"/> Reading <input type="checkbox"/> Biking <input type="checkbox"/> Arts/Crafts <input type="checkbox"/> Computer <input type="checkbox"/> Boating <input type="checkbox"/> Water sports <input type="checkbox"/> Sewing <input type="checkbox"/> Hunting <input type="checkbox"/> Watch TV <input type="checkbox"/> Driving <input type="checkbox"/> Music <input type="checkbox"/> Snow sports <input type="checkbox"/> Fishing <input type="checkbox"/> Competitive sports <input type="checkbox"/> Video games			
Date of Last Eye Exam _____		Name of Eye Doctor _____		➤ Do your eyes seem bothered by glare from any of the following situations? <input type="checkbox"/> Car headlights <input type="checkbox"/> Computer monitor <input type="checkbox"/> Traffic lights <input type="checkbox"/> Fluorescent lights <input type="checkbox"/> Night driving <input type="checkbox"/> Sunshine <input type="checkbox"/> Bright Lights <input type="checkbox"/> Other _____			
Have You Ever Been Treated For Or Diagnosed With Any Of The Following? <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Eye Infection <input type="checkbox"/> Amblyopia/Lazy Eye <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Strabismus/Crossed Eye <input type="checkbox"/> Retinal Problems <input type="checkbox"/> Eye Trauma				➤ Do you have other prescription glasses? <input type="checkbox"/> Sunglasses <input type="checkbox"/> Reading glasses <input type="checkbox"/> Sports glasses <input type="checkbox"/> Other _____			
Do You Experience Any Of The Following? <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Burning <input type="checkbox"/> Flashes of Light <input type="checkbox"/> Double Vision <input type="checkbox"/> Itching <input type="checkbox"/> Floaters <input type="checkbox"/> Dryness <input type="checkbox"/> Tearing <input type="checkbox"/> Eye Pain <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Redness <input type="checkbox"/> Unexplained Headaches				➤ What do you like about your current glasses or contacts? (color, style, fit, etc.) _____ _____			
Do You Have A Family History Of The Following? <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Hypertension <input type="checkbox"/> Amblyopia/Lazy Eye <input type="checkbox"/> Strabismus/Crossed Eyes <input type="checkbox"/> Blindness <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Cataracts				➤ What do you dislike about your current glasses? (weight, thickness, glare) _____ _____			
LIST MEDICATIONS:		LIST ALLERGIES:					