

WELCOME TO MAIN STREET OPTOMETRY

PATIENT INFORMATION

Last Name	First Name	MI	Date	
Address	City	State	Zip	
Date of Birth	Age	Home Phone	Alternate Number – Work or Cell	Email Address

INSURANCE INFORMATION

Vision Insurance Company	Health Insurance Company	Relationship to Insured
Name of Insured	Insured's Birth Date	Insured's Employer
Contract Number	Group Number	Insured's Social Security Number

HEALTH QUESTIONARE

Date of last physical _____ Name of Physician _____

DO YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING CONDITIONS?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Are You Pregnant?
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke/Neurological	<input type="checkbox"/> Arthritis	How Far Along? _____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cardiovascular Problems	<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Thyroid Problem	<input type="checkbox"/> Blood Clot/Bleeding	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Sickle Cell/Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Other _____

Date of last eye exam _____

HAVE YOU EVER BEEN TREATED FOR OR DIAGNOSED WITH ANY OF THE FOLLOWING?

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Eye Infection	<input type="checkbox"/> Blindness
<input type="checkbox"/> Amblyopia/Lazy Eye	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Eye Surgery	
<input type="checkbox"/> Strabismus/Crossed Eye	<input type="checkbox"/> Retinal Problems	<input type="checkbox"/> Eye Trauma	

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

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"/> Light Sensitivity
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Itching	<input type="checkbox"/> Floaters	<input type="checkbox"/> Redness
<input type="checkbox"/> Dryness	<input type="checkbox"/> Tearing	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Unexplained Headache

PLEASE LIST ALL MEDICATIONS:

PLEASE LIST ALL ALLERGIES:

HOW DID YOU HEAR ABOUT US?

<input type="checkbox"/> Internet	<input type="checkbox"/> Newspaper	<input type="checkbox"/> Phonebook	<input type="checkbox"/> Friend/Family	<input type="checkbox"/> Drive-by	<input type="checkbox"/> Other _____
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