Reno Family Eye Care, P.C
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Welcome to Our Office

Today's Date ____________
Last ____________ First ____________ MI___
Street ______________________
City ____________ State _____ Zip Code_______
Home Phone ______________________
Cell/Work Phone ______________________
Email Address ______________________
Patient's Social Security Number ____________
Date of Birth ___/___/____ Age _____ Gender M F
Employer (or School): ______________________
Occupation (or Grade): ______________________
Spouse (or Parent's) Name: ______________________
Spouse (or Parent's) Work: ______________________

What is the major purpose of this visit?
____
Any problems with your current glasses or contacts?
____
Do you plan on getting new glasses/contacts today? Y N

VERY IMPORTANT! **NEW PATIENTS ONLY:**
Who may we thank for referring you to our office?
Name of friend or relative ______________________
If not referred, how did you choose our office?
o Another Doctor o Insurance List
o Saw Sign/Building o Newspaper/Radio/TV
o Yellow Pages Which directory? ____________
o Web Page Which website? ____________
o Other ______________________

Insurance Information

Vision Insurance: ______________________
Subscriber Name: ______________________
Subscriber Social Security Number: ____________
Subscriber Birth Date: ______________________

Medical Insurance: ______________________
Subscriber Name: ______________________
Subscriber Social Security Number: ____________
Subscriber Birth Date: ______________________

Do you participate in a flex spending account? Y N
How will you settle your account today?
oCash oCheck oCredit Card

Family Eye/Medical History

Is there a medical history of any of the following?

		Relationship
Glaucoma	o	____________
Macular Degeneration	o	____________
Cataracts	o	____________
Lazy Eye	o	____________
Blindness	o	____________
Corneal Problems	o	____________
Retinal Problems	o	____________
Diabetes	o	____________
Heart Disease	o	____________

The information on this confidential case history form is critical in the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ______________________
Office Name ____________ City ____________ State _____

Date of Last Physical Check-up ______________________
CURRENT MEDICATIONS (Rx or Over the Counter)
List all medications, including eye drops, vitamins & birth control:
____
____
Allergies to Medications? oYes o No
____
____
Tobacco Use: o No o Yes Amount ________Pack/Day
WOMEN ONLY: Are you currently pregnant? oYes oNo

Have you ever been diagnosed or treated for the following?
o Allergies o Diabetes o Thyroid
o Arthritis o Heart Disease o Other ____________
o Asthma o High Blood Pressure ____________
o Cancer o Kidney
o Cholesterol o Neurologic

Patient Eye History

Date of Last Eye Exam ______________________
By whom? ______________________
Do you currently wear glasses? Yes No Contacts? Yes No
Are you satisfied with the vision and comfort? o Yes o No
What kind of contact lenses do you wear? ____________
Replacement Schedule ______________________
Do you ever sleep in your lenses? ______ Solutions ____________
Are you interested in trying contact lenses? o Yes o No
Have you had Vision Correction Surgery? o Yes o No
If so, where and when? ______________________

Do you… (Check if your answer is yes)
o …work at a computer
o …think you may benefit from thinner, lighter lenses?
o …have interest in a "Test Drive" of the latest in contact lens?
o …spend time outdoors? _________hrs/week
o …have prescription sunglasses or more than 1 pair of glasses?
o …want information on Laser Vision Correction Surgery?
o …have interest in a non-surgical approach to vision correction?
o …have children?
o …have family members in need of eye care?

If you wear traditional bifocals, does the line or head tilting bother you? o Yes o No

Have you ever been diagnosed or treated for the following?
o Cataracts o Iritis / Uveitis
o Corneal Abrasion o Lazy Eye
o Eye Infection o Macular Degeneration
o Eye Injury o Retinal Detachment
o Glaucoma o Other Eye Disorders

Are you experiencing any of the following?
o Blurry Vision o Headaches
o Burning o Itching
o Crossed Eye / Eye Turn o Night Vision Problems
o Double Vision o Sunlight sensitivity
o Dryness / Grittiness o Tearing
o Flashes of light o Uncomfortable glasses
o Floaters o Other ____________