

***Welcome to Our Office***

**Personal Information**

Today's Date: \_\_\_\_\_

Your Legal Name \_\_\_\_\_ Preferred Name(if different) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_  
 Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
 Email Address \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Hobbies \_\_\_\_\_  
 Emergency Contact Name/Number \_\_\_\_\_  
 Date of Last Eye Exam \_\_\_\_\_ Dr's Name \_\_\_\_\_ Dilated? \_\_\_\_\_  
 Name of your Vision Plan \_\_\_\_\_  
 Name of your Medical Insurance \_\_\_\_\_

**Medical Information**

Please check the appropriate box(s) for any condition you have had or are currently being treated for:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Musculoskeletal     | <input type="checkbox"/> Thyroid              |
| <input type="checkbox"/> Ear/Nose/Throat  | <input type="checkbox"/> Integumentary(skin) | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Cardiovascular   | <input type="checkbox"/> Mental              | <input type="checkbox"/> Endocrine(glands)    |
| <input type="checkbox"/> Respiratory      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes(Type )      |
| <input type="checkbox"/> Nervous          | <input type="checkbox"/> Immunologic         | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Genitourinary    | <input type="checkbox"/> Blood/Lymph         |   |

Please Explain \_\_\_\_\_

Please list all medications you are currently taking \_\_\_\_\_

Please list any other illness, diseases, conditions, or surgeries you may have had \_\_\_\_\_

Please list any drug allergies \_\_\_\_\_

Do you use cigarettes/tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Other substance(s)? \_\_\_\_\_

Name of family doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Breastfeeding? \_\_\_\_\_

**Family History**

- |   |   |
|---|---|
| <input type="checkbox"/> High blood pressure; Relation _____  | <input type="checkbox"/> Cancer; Relation _____ Type _____      |
| <input type="checkbox"/> Diabetes; Relation _____             | <input type="checkbox"/> Cataracts; Relation _____              |
| <input type="checkbox"/> Glaucoma; Relation _____             | <input type="checkbox"/> Other eye conditions; What Kind? _____ |
| <input type="checkbox"/> Macular Degeneration; Relation _____ |   |
| <input type="checkbox"/> Retinal Detachment; Relation _____   |   |

***See Other Side***

DR. INITIALS \_\_\_\_\_

**Personal Eye Information**

- Glaucoma
- Cataracts
- Macular Degeneration
- Dry eyes
- Blurred vision

Have you had any eye operations or injury? Please explain \_\_\_\_\_

Which do you wear most:  Glasses  Contacts  Both

Do you wear sunglasses? \_\_\_\_\_

Type of glasses:  Single vision  Progressive bifocal  Conventional bifocal  Trifocal

Type of contacts:  Soft  Hard  Gas Permeable  Toric

Brand \_\_\_\_\_

How often do you dispose of your contacts? \_\_\_\_\_

Are you satisfied with the comfort and vision of your current glasses and/or contacts ? \_\_\_\_\_

Did you know that we have a Refractive Surgery Center (LASIK) on site? \_\_\_\_\_  
Are you interested in more information about LASIK? \_\_\_\_\_

**Please indicate for our records if you heard about us through the following sources.**

- Optometrist(Name: \_\_\_\_\_ )
- Another patient(Name: \_\_\_\_\_ )
- Insurance list
- Yellow pages
- RSVP mailer
- [www.doughertylaservision.com](http://www.doughertylaservision.com)
- Dr's Doctor Ad/Mailer
- Mall Kiosk in Ventura
- Chamber
- Outdoor Event
- Internet Search

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DR. INITIALS \_\_\_\_\_