



Welcome to our office! In order to provide the most comprehensive eye exam possible, we request your assistance in filling out this health history form. The information provided will be held in strict confidence. Thank You!

Today's Date _____ Age _____

PERSONAL INFORMATION

Patient's Name _____ Date of Birth _____ Sex M F
Social Sec. # _____ Occupation _____ Eye Color _____
Home Address _____ City _____ Zip _____
Home Phone _____ If child, parents' names _____
Work Phone _____ Employer _____ E-mail: _____
If married, spouse's name _____ Occupation _____
Dependent children: Name _____ Age _____ Name _____ Age _____ Name _____ Age _____
Where did you hear about our practice: [] Phone Book [] Newspaper [] Radio [] Mailing [] Friend
Whom may we thank for referring you to us? _____

MEDICAL HISTORY

Please check if any of the following pertain to you:
[] Diabetes [] High Blood Pressure [] Heart Disease [] Medication Reactions
[] Allergies/Hay Fever [] Thyroid Problems [] Nerve Problems [] Other
Are you under physician's care for any disease or condition at this time? [] Yes [] No Physician _____
If so, what medications are you currently taking? _____

EYE HEALTH HISTORY

What is your reason for today's eye examination? (Check those that apply)
[] Time for exam [] Contact lenses [] Sensitive to lights [] Red eyes
[] Broken/Scratched glasses [] Blur at near [] Headaches [] Dry eyes
[] Want new frames [] Blur at far [] Double vision [] Eyes itch/water
[] Driver's license [] Eye health exam [] Eye strain/tire [] Other
Have you ever had any eye injuries, diseases or eye surgery? [] Yes [] No If yes, explain: _____
Has anyone in your immediate family had any eye diseases? _____
When was the last time you saw an eye doctor for an examination? _____ Doctor _____
Where did you last purchase eyeglasses or contact lenses? _____
Do you work at a computer terminal? [] Yes [] No
List your hobbies that require good vision _____
Do you want a complimentary in-office contact lens trial during your exam? [] Yes [] No
I would like to discuss the advisability of:
[] Prescription sunglasses [] Disposable/extended wear contact lenses [] Computer glasses
[] Soft contact lenses [] Gas permeable hard contact lenses [] Sports eyewear
[] Tinted contact lenses [] Contact lenses for astigmatism [] Invisible bifocals

FINANCIAL INFORMATION

Who is responsible for payment of account (if other than patient)?
Name _____ Relationship _____
Home Address _____ Home Phone _____ Work Phone _____
PAYMENT OPTIONS (Check one) Account will be paid with [] Cash [] Check [] Credit Card
[] I plan to make full payment for services and materials today.
[] I plan to make full payment for services and half the cost of materials today. I will pay the balance due upon receipt of the materials.
Please submit appropriate items to [] Insurance Policy # [] Medicare Policy # [] Social Services Policy #
Insurance Name: _____

Thank you for choosing our office for your eyecare. Every effort will be made to provide you with the finest vision care available while making your evaluation a pleasant experience!

Dr. Kent Fronk

Dr. Steve Looyen