MODERN EYES OPTICAL

Patient #_____

Today's date:_____/_____/_____

Patient Information

First Name_____ Last Name_____ Preferred Name_____ Birth date ____/____/_____ ☐M ☐F

Address_____ City_____ State_____ ZIP_____

Home Phone (_____)_____ Mobile Phone (_____)_____ Email_____

Hispanic or Latino? ☐Yes ☐No Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White

Employer/School_____ Occupation/Grade_____ Preferred Language: ☐English ☐Spanish

Parent/Guardian (if under 18)_____ Relationship: ☐Father ☐Mother ☐Guardian Phone(_____)_____

Emergency Contact_____ Relationship_____ Phone(_____)_____

Primary Care Provider_____ Last Visit_____ Preferred Pharmacy:_____

Referred By_____ Other family members who are current patients? ☐Yes ☐No Medicare / Medicaid? ☐Yes ☐No

Medical & Ocular History

Reason for today's visit:_____

Last Eye Exam (m/y):_____ Last Eye Doctor:_____ Last Pupil Dilation:_____

Do you wear: **Glasses** ☐ Yes ☐ No If yes, age of current glasses_____ **Contact lenses** ☐ Yes ☐ No If yes, what type_____

How many hours on an average day do you spend on digital devices?_____ Do you have sunglasses? ☐ Yes ☐ No

Do you have any of the following conditions? (*Please check all that apply, must select at least one, list any others*)

☐ Glaucoma	☐ Retinal Tear/Detachment	☐ Eye Surgery (incl Laser)	☐ Thyroid Problems	☐ Currently Pregnant
☐ Cataracts	☐ Strabismus (Crossed Eyes)	☐ Double Vision	☐ Heart Disease	☐ Other:_____
☐ Macular Degeneration	☐ Amblyopia (Lazy Eye)	☐ Frequent Headaches	☐ Cancer	☐ Other:_____
☐ Retinal Disease	☐ Eye Injury/Trauma	☐ Diabetes	☐ Rheumatoid Arthritis	
☐ Uveitis/Inflammation	☐ Blindness	☐ High Blood Pressure	☐ Asthma	☐ **NONE OF THE ABOVE**

Please explain any items you selected above:_____

_____

Surgeries you have had:_____

Medications/Supplements/Eye Drops you take: (include name/dosage/frequency)_____

_____

Allergies: ☐ NONE ☐ Latex ☐ Iodine ☐ Medications (list including reaction)_____

Personal History: Smoker: ☐ Current ☐ Previous ☐ Never **Drugs**: ☐ Sometimes ☐ Previous ☐ Never **Alcohol**: ☐ Frequent ☐ Occasional ☐ Never

Do any of your relatives, living or deceased, have any of the following conditions? (*Please check all that apply, circle relative(s)*)

☐ Glaucoma	M,F,MGM,MGF,PGM,PGF,SIB	☐ Blindness	M,F,MGM,MGF,PGM,PGF,SIB	☐ High Blood Pressure	M,F,MGM,MGF,PGM,PGF,SIB
☐ Cataracts	M,F,MGM,MGF,PGM,PGF,SIB	☐ Strabismus (Crossed Eyes)	M,F,MGM,MGF,PGM,PGF,SIB	☐ Cancer	M,F,MGM,MGF,PGM,PGF,SIB
☐ Macular Degeneration	M,F,MGM,MGF,PGM,PGF,SIB	☐ Amblyopia (Lazy Eye)	M,F,MGM,MGF,PGM,PGF,SIB	☐ Other:_____	M,F,MGM,MGF,PGM,PGF,SIB
☐ Retinal Tear/Detachment	M,F,MGM,MGF,PGM,PGF,SIB	☐ Diabetes	M,F,MGM,MGF,PGM,PGF,SIB	☐ **NONE OF THE ABOVE**	

Signature of Patient (Parent/Guardian if minor)_____ Date _____/_____/_____

Office Use: Date_____ ☐ Changes ☐ No Changes Initial_____

Date_____ ☐ Changes ☐ No Changes Initial_____