Bellaire • Welcome to our Office • Champions

Full Name ______________________
Nickname ______________________
Date of Birth __________ Age ____ Sex: M F
Employer/School ______________________
Occupation/Grade ______________________
Emergency Contact ______________________
Emergency Phone ______________________

Guarantor's Name (if different) ______________________
Relationship to Patient ______________________
Billing Address ______________________
City ____________ State _____ Zip _________
SS# ____________ Work Ph ____________
Home Ph ____________ Cell Ph ____________
Best Number to reach you (circle): Home Work Cell
E-mail Address ______________________

Personal and Family History (parent, grandparent, sibling, children) Please check any of the following for which you or a family member has a history. List relationship and specifics below.

	Self	Family		Self	Family
Retinal Disease	☐	☐	Eye Surgery	☐	☐
Glaucoma	☐	☐	Thyroid	☐	☐
Cataracts	☐	☐	Arthritis	☐	☐
Macular Degeneration	☐	☐	Systemic Lupus	☐	☐
Strabismus/Crossed Eye	☐	☐	Multiple Sclerosis	☐	☐
Amblyopia / Lazy Eye	☐	☐	Diabetes	☐	☐
ADD/ADHD	☐	☐	Heart Disease	☐	☐
Learning Disability / Dyslexia	☐	☐	High Blood Pressure	☐	☐
Autism/PPD	☐	☐	Migraines	☐	☐
Sensory Integration Issues	☐	☐	Seizure Disorder	☐	☐

Other Medical Conditions ______________________
Current State of Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How did you choose our office for your eye care?

- ☐ Family / Friend Referral ______________________
- ☐ Professional Referral ______________________
- ☐ Insurance Provider List ______________________
- ☐ Advertisement In ______________________
- ☐ Website ______________________

Today's Date ______________________
What is the primary purpose of today's visit? _______
____
____
Last Vision Exam: ______________________
Office/Doctor: ______________________

Do You…
Currently wear glasses? Y N For: __________
Currently wear contacts? Y N
If so, what kind ______________________
Replacement Schedule ______________________
Are You…
Interested in wearing contacts? Y N
Interested in Laser Vision Correction? Y N

Do You…
Play Competitive Sports? Y N
Type(s) ______________________
Position(s) ______________________
Work on the computer more than 4 hrs/day? Y N
Perform other nearwork more than 4 hrs/day? Y N

Do you experience…

- ☐ Redness
- ☐ Spots / Floaters
- ☐ Flashes of light
- ☐ Double vision
- ☐ Blurry distance vision
- ☐ Blurry near vision
- ☐ Sudden loss of vision
- ☐ Discomfort in Glasses
- ☐ Discomfort in Contacts
- ☐ Glare or Reflection
- ☐ Tearing / Burning
- ☐ Dryness
- ☐ Eye Strain
- ☐ Soreness of eyes
- ☐ Tinnitus/Ears Ringing
- ☐ Itchy Eyes
- ☐ Headaches
- ☐ Nausea
- ☐ Dizziness / Imbalance
- ☐ Sensitivity to sounds
- ☐ Carsickness
- ☐ Fatigue when reading
- ☐ Inattentiveness
- ☐ Poor Night Vision
- ☐ Lack of coordination
- ☐ Difficulty after Car Accident
- ☐ Flicker Sensitivity
- ☐ Trouble walking up or down stairs
- ☐ Light Sensitivity
- ☐ Other

Current Medications (Rx or Over the counter)
1.
2.
3.
4.
5.
6.

Current Vitamins or Nutritional Supplements
1.
2.
3.
4.

Allergies to Medications? Y / N
If so, please list:
1.
2.
3.
4.