WELCOME TO OUR OFFICE

Doctors Cooper & Link, Optometrists, A.P.C.

Name _____ Today's Date _____

Address _____ Phone #s _____

City_____State_____Zip_____ Cell Phone #_____

Date of Birth _____ Social Security # _____E-Mail_____

Occupation _____ Employer/School & Grade _____

Vision Insurance_____Medical Insurance _____

Spouse or Parent's Name _____ Which Other Family Members are patients here?_____

How did you find out about our office?

□ Yellow Pages □ Internet □ Referred by _____ □ School referral

Medical and Vision History

When was your last eye exam? _____ Last Physical/Check up _____

Do you have any significant allergies (hay fever, foods,etc.) ?_____

List any *major* surgeries you've had _____

List any eye surgeries or injuries you have had _____

List any eye conditions you know you have _____

Do you use eye drops? □ yes □ no please list, how often _____

Do you wear glasses? □ yes □ no For: □ full time □ other _____

Do you wear contact lenses? □ yes □ no □ I used to, I stopped because _____

Type of contacts: □ soft □ disposable □ rigid . How often do you put in fresh lenses?_____

What brand of solutions do you use with your contacts? _____

Social History

Do you drive? □ yes □ no Do you have visual difficulty while driving? □ yes □ no

Do you use tobacco products □ yes □ no How much/type _____

How many hours per day do you look at computer screens? _____

What hobbies or sports do you participate in? _____

Your Own Medical History

Name of your primary medical doctor(s): _____

Do you have any **problems** in the following areas:

	YES	NO		YES	NO	Family
Loss of Vision	☐	☐	Diabetes	☐	☐	☐
Blurred Vision	☐	☐	High Cholesterol	☐	☐	☐
Reading Disorder	☐	☐	High Blood Pressure	☐	☐	☐
Double Vision	☐	☐	Crossed Eyes	☐	☐	☐
Eye Strain	☐	☐	Glaucoma	☐	☐	☐
Dryness	☐	☐	Migraines	☐	☐	☐
Mucous Discharge	☐	☐	Asthma	☐	☐	☐
Redness	☐	☐	COPD/Emphysema	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	Heart Disease	☐	☐	☐
Itching	☐	☐	Hormone Imbalance	☐	☐	
Burning	☐	☐	Stomach/Intestine disorder	☐	☐	
Excess Watering	☐	☐	Arthritis	☐	☐	
Eye Pain or soreness	☐	☐	Are you HIV +	☐	☐	
Glare/Light Sensitivity	☐	☐	Immune System disorder	☐	☐	☐
Loss of side vision	☐	☐	Depression	☐	☐	
Styes	☐	☐	Psychiatric disorder	☐	☐	
Infections of eye or lid	☐	☐	Hepatitis	☐	☐	
Floaters	☐	☐	Skin Cancer	☐	☐	
Flashing Lights	☐	☐	Thyroid	☐	☐	
			Blindness	☐	☐	☐
Sleep Apnea	☐	☐	Macular Degeneration	☐	☐	☐
Headaches	☐	☐	Cataracts	☐	☐	☐
Allergies/Hay Fever	☐	☐	Lazy Eye	☐	☐	☐

List any medications you take (including aspirin, over the counter remedies, birth control, herbals, vitamins):

☐ Separate List Brought_____ _____ _____

_____ _____ _____ _____

What medications are you allergic to, or can **not** have? _____ _____

Dr has read this_____