

Randolph Brooks, O.D.
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WELCOME TO OUR OFFICE

Today's Date _____
 Mr. ___ Mrs. ___ Ms. ___ Miss ___ Dr. ___
 Last _____ First _____ MI _____
 Street _____
 City _____ State _____ Zip Code _____
 Home Phone # _____
 Work # _____ Cell # _____
 Emergency contact & number _____
 Date of Birth _____ Age _____ Sex M F
 Patient's Social Security Number: _____
 Employer (or School): _____
 Occupation (or Grade): _____
 Hobbies _____
 Spouse (or Parent's Name): _____
 Spouse (or Parent's Work): _____
 Email address for our office newsletters and eye health updates:

 Any problems with your present contact lenses or glasses?

Patient Medical History
 Name of Family Physician _____
 Town _____
 Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)
 (List name of medications including eye drops, vitamins & birth control pills) _____

 Allergies to Medications: No Yes _____

Have you ever been diagnosed or treated for the following?
 Allergies Diabetes Nerves
 Asthma Heart Disease Thyroid
 Arthritis High Blood Pressure Other _____
 Cancer Kidney _____
 Cholesterol Lyme Disease _____

Patient Eye History
 Date of Last Eye Exam _____
 By Whom? _____
 Do you currently wear contact lenses? Yes No
 What kind? _____
 Solutions Used _____
 If not, are you interested in contact lenses? Yes No
 Do you want to change the color of your eyes? Yes No
This is a \$55 fee to evaluate your *current* contact lenses.
This fee is not covered by your vision or managed care plan.

Insurance Information

Vision Insurance: _____
 Subscriber Name: _____
 Subscriber Social Security Number: _____
 Subscriber Birthdate: _____

Medical Insurance: _____
 Subscriber Name: _____
 Subscriber Social Security Number: _____
 Subscriber Birthdate: _____

Secondary Medical Insurance: _____
 Subscriber Name: _____
 Subscriber Social Security Number: _____
 Subscriber Birthdate: _____

Do you participate in a flex spending account? No Yes
 How will you settle your account today?
 Check Cash Credit Card

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?
 Relationship

Blindness	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	_____
Corneal Problems	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____
Retinal Problems	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____
Other Eye disease or surgery	<input type="checkbox"/>	_____

Do you...
 ...Have more than 1 pr. of current Rx glasses? Yes No
 ...Work at a computer for long periods? Yes No
 ...Want information on thinner, lightweight lenses? Yes No
 ...Have times you would rather not wear your glasses? Yes No
 ...Spend time outdoors? (How much?) _____ hrs/wk
 ...Have 100% UV absorbing sunglasses? Yes No
 ...Want information on Laser Vision Correction? Yes No
 ...Have children? Yes Age(s): _____ No
 ...Have family members in need of eyecare now? Yes No

Have you ever been diagnosed or treated for the following?
 Cataracts Glaucoma Retinal Detachment
 Corneal abrasion Iritis/Uveitis Other eye disorders
 Eye infection Lazy Eye
 Eye injury Macular Degeneration

Do you experience or have you ever experienced?

<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Flashes of light	<input type="checkbox"/> Redness
<input type="checkbox"/> Burning	<input type="checkbox"/> Floaters/spots	<input type="checkbox"/> Tearing
<input type="checkbox"/> Crossed eye/eye turn	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Trouble seeing at night or glare
<input type="checkbox"/> Double vision	<input type="checkbox"/> Headaches	<input type="checkbox"/> Uncomfortable glasses
<input type="checkbox"/> Dryness	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Uncomfortable contact lenses
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Light sensitivity	
<input type="checkbox"/> Eye strain	<input type="checkbox"/> Reading problems	

VERY IMPORTANT! NEW PATIENTS ONLY:
 Who may we thank for referring you to our office?
 Name of friend or relative _____
 If not referred, how did you choose our office for your visual needs?
 Relative Friend Another Dr.
 Insurance List Yellow Pages- Which Directory? _____
 Saw Sign/Building Web Page - Which Web site? _____
 Other _____