Welcome to the office of Dr. H. Jeff Ward, Optometrist

Please take the time to provide the following information. If you have any questions or concerns, the staff will be happy to assist you in any manner necessary. Please be assured that any information you provide will be held strictly confidential.

Patient Information: Date: _____

Name: _____ Gender: M F DOB: _____

Home Ph: (_____) _____ Cell Ph: (_____) _____

Business Ph: (_____) _____ Extension: _____

Address: _____

City: _____ St: _____ Zip: _____

Occupation: _____ Employer: _____

Email address: _____ SSN: _____

Vision Insurance Plan:_____ Member Name: _____

Member DOB: _____ Member SSN: _____

Medical Insurance Plan: _____ Member Name: _____

Member DOB: _____ Member SSN: _____

Medical Insurance Member ID: _____ Medical Insurance Group Number:_____

Marital Status (circle one): Single Married Divorced Widowed

Person to contact in the event of an emergency: _____ Phone (_____) _____

Person responsible for payment of account: _____ Phone (_____) _____

Responsible Party's Address (if different from above): _____

City: _____ St: _____ Zip: _____

Please let us know how you discovered our office (circle one)?

Relative Friend Yellow Pages Internet Search Insurance Plan List/Website Advertisement

Other:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered and any materials purchased (i.e. prescription glasses, contact lenses, etc.). I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature: _____ Date:_____

Parent (if minor): _____ Date: _____

Medical and Ocular History

Please provide the following information to the best of your knowledge. Any information you provide will be held strictly confidential.

Primary reason for today's visit: □ glasses □ contacts

□ eye emergency □ eye health evaluation □ other: _____

How many years since your last eye exam? _____

How many years since your eyes were dilated? _____

Have you ever had any serious eye injuries? Yes No

If yes, please describe: _____

Have you ever had vision therapy? Yes No

Have you ever had eye surgery? Yes No

If yes, please describe: _____

Would you like to learn more about **refractive surgery (LASIK)**? *Circle answer* Yes No

Would you like to learn about **Orthokeratology (Ortho-K)**? This safe and new treatment option involves the use of a specialty contact lens to gently reshape the cornea while a patient sleeps. In the morning, the patient removes the contact lenses and attains great vision for all of his/her waking hours without the need for daytime glasses or contact lenses.

Circle answer Yes No

Please list any hobbies:

Ocular Symptoms: *Please check all symptoms you are currently experiencing:*

□ Blurry vision at distance
□ Blurry vision at near
□ Vision related headaches
□ Eye discharge
□ Double vision
□ Dry eyes
□ Itchy eyes
□ Painful eye(s)
□ Eye strain
□ Difficulty changing focus from far to near and/or near to far

Visual Performance Challenges: *Please check all visual challenges that you regularly experience*

□ Night driving difficulty
□ Discomfort due to glare
□ Sensitivity to bright light
□ Difficulty seeing objects against their background
□ Color vision problems

Computer Vison Issues: *Check the appropriate box for each issue*

	None	*Mild*	*Mod*	*Severe*
Headaches during/after computer use	□	□	□	□
Difficulty focusing words on screen	□	□	□	□
Need for frequent breaks	□	□	□	□
Distance vision worse after computer use	□	□	□	□

Typically, how many hours a day do you work on the computer? _____

Do you use a laptop? Yes No

Health Information:

How many years since your last physical exam? _____

Were there any abnormal findings? Yes No

If yes, please list: _____

Overall, how would you describe your health? (circle answer)

Excellent good fair poor

Do you smoke? Yes No If yes, how many years? _____

Please list all **medications** you are currently taking:

Please list **allergies** to medications:

Medical History: Please check all conditions that apply to you or an immediate family member:

Self	Family	
□	□	Glaucoma
□	□	Age Related Macular Degeneration
□	□	Cataract(s)
□	□	Retinal detachment(s)
□	□	Other eye condition(s): _____
□	□	High blood Pressure
□	□	Diabetes
□	□	Heart Disease
□	□	Thyroid disease
□	□	High cholesterol
□	□	HIV/AIDS
□	□	Hepatitis
□	□	Autoimmune Disorder (i.e. Lupus)
□	□	Arthritis
□	□	Herpes
□	□	Cancer
□	□	Kidney Disease
□	□	Asthma
□	□	Seasonal allergies
□	□	Emphysema
□	□	Other medical condition(s) _____

DILATION: During the eye examination, your eye care professional may wish to utilize eye drops so that he can better assess the health of your eyes. These eye drops dilate the pupils, blur near vision, and cause increased sensitivity to light, but only on a temporary basis (3-4 hours, typically).

□ **Yes**, I agree to have my eyes dilated today if my eye care professional feels it is necessary.

□ **No**, I do not wish to have my eyes dilated today even if my eye care professional recommends it.