WELCOME TO EYE & EAR

BOYNTON BEACH / PALM SPRINGS

Last Name_______________________ First Name_______________________ SS #_______________________

Male _____ Female _____ Date of Birth ____________________ Age ________________ Email ______________________

Street Address ____ Apt #______________________

City ____________________________________ State______________________ Zip Code____________________

Home Telephone (________)______________________________ Work Telephone (________)______________________________

Employer ______________________________________ Occupation ______________________________________

Hobbies ______________________________________ Sports ______________________________________

Primary Vision Care Plan ______________________________ ID # ______________________________________

Other Health Plan ______________________________ ID # ______________________________________

Insured's Name ______________________________ Insured's Date of Birth ______________________________

Insured's SS # ______________________________

How did you learn about our office?

❑ Walk By ❑ Insurance Plan ❑ Yellow Pages ❑ Other ______________________________

❑ Doctor ❑ A Previous Patient ❑ Advertisement

Name of person who referred you ____________________ How do you know each other? ____________________

HEALTH HISTORY

	Self	Family
Blindness	❑	❑
Cataracts / Cataract Surgery	❑	❑
Color Blindness	❑	❑
Crossed or Lazy Eye	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Retinal Disease	❑	❑
Vision Correction Surgery	❑	❑
Asthma / Lung Disorder	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Heart Problems	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Thyroid Problems	❑	❑

Drug Allergies? ❑Yes ❑ No

Are you Pregnant? ❑Yes ❑ No

EYEGLASSES

YOUR GLASSES ARE?

❑ With you ❑ Home ❑ Lost / Broken

HOW OLD ARE THEY?

❑ 1-2 yrs ❑ 3-4 yrs ❑ Over 4 yrs

YOU WEAR THEM?

❑ All the time ❑ Sometimes ❑ Rarely ❑ Never

ANY PROBLEMS SEEING WITH YOUR GLASSES?

❑ Far away ❑ Up close ❑ Not sure ❑ No

ARE THEY?

❑ No Line Bifocals ❑ Bifocals ❑ Single Vision

❑ Distance glasses ❑ Reading glasses

❑ Computer glasses

CONTACT LENSES

DO YOU WEAR CONTACT LENSES?

(CHECK ALL THAT APPLY)

❑ No ❑ Yes ❑ Soft ❑ RGP / Hard ❑ DailyWear

❑ Extended Wear ❑ Colors ❑ Disposables

❑ Daily ❑ 2 week ❑ Monthly ❑ Quarterly

❑ Torics(astigmatism)❑ Bifocals ❑ Monovision

❑ Reading glasses over contacts

❑ Brand and power if known **RT** ____________

LT ____________

YOU LAST HAD YOUR CONTACTS IN?

❑ Now ❑ Days ❑ Weeks ❑ Months ❑ Years

ANY PROBLEMS SEEING WITH YOUR CONTACTS?

❑ Yes ❑ No ❑ Not sure

Reason for today's visit?

❑ Annual exam ❑ New Glasses ❑ Contact Lenses ❑ Red Eye ❑ Other ____________________

Date of Last Eye Exam _____________ With Dr. ______________________ City / State ______________________

List any MEDICATIONS you are taking? ____

Describe any injury or surgery to your eyes or any information about your eyes that you would like us to know:_________

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PLEASE SEE NEXT PAGE ➡