Welcome to Our Office! **Perfect Vision** Drs. Mark & Sheryl Pickering

We know how annoying it is to fill out these forms. However most of this information is required by the insurance companies and a lot of it will actually be helpful in assessing what will work best for your visual needs. Please indulge us by gritting your teeth and doing your best to provide us with accurate information to use for your best possible eye care. Thanks.

PERSONAL INFORMATION

Date _____

Mr. Mrs. Ms. Miss Dr. _____

Address _____ Apt. _____

City _____ State _____ Zip _____

Home Phone _____ Birth Date _____ Age _____

Work Phone _____ Ext. _____ Employer _____

Cell Phone _____ SS# _____ Marital Status: M S D W

Occupation _____ E-mail Address _____

☺ Most of our patients come to us by referral and we like to thank those who recommend us to their friends or loved ones. ☺
☺ Please provide us with the name of the person who referred you to our office so we can thank them properly. ☺

_____

If not by referral, how did you find out about our office?

☐Saw our sign ☐Insurance Provider List ☐Internet (*what source?*) ☐G&L Yellow Pages ☐Mail Out ☐Other

_____

MEDICAL HISTORY

EYE HISTORY:	Yes	No	In Family		Yes	No	In Family
Glaucoma	☐	☐	☐	Other Eye Diseases	☐	☐	☐
Cataract	☐	☐	☐	If yes, please explain	_____		
"Lazy Eye"	☐	☐	☐	Eye Surgery	☐	☐	☐
Macular Degeneration	☐	☐	☐	If yes, please explain	_____		
Retinal Detachment	☐	☐	☐	Eye Injury (explain)	_____		
GENERAL HEALTH HISTORY:							
Allergies	☐	☐	☐	Cholesterol	☐	☐	☐
Anxiety/Depression	☐	☐	☐	Heart Disease	☐	☐	☐
Arthritis	☐	☐	☐	High Blood Pressure	☐	☐	☐
Asthma	☐	☐	☐	Kidney Problems	☐	☐	☐
Autoimmune Disorder	☐	☐	☐	Skin Disorder	☐	☐	☐
Diabetes	☐	☐	☐	Thyroid Disorder	☐	☐	☐
Cancer	☐	☐	☐	Other	_____		

MEDICATIONS: (*Prescription or OTC*)	Name of Medication		Name of Medication
☐ Allergy Medications	_____	☐ Skin Treatments	_____
☐ Analgesics (pain)	_____	☐ Vitamins	_____
☐ Blood Pressure Pills	_____	☐ Herbal Supplements	_____
☐ Diuretic (water pill)	_____	☐ Anti-Aging Creams	_____
☐ Oral Contraceptives	_____	☐ Eye Drops	_____
☐ Other Medications	_____		
☐ Are you allergic to any medications?	_____		

VISION RELATED INFORMATION

Name of Previous Eye Doctor _____ Date of Last Eye Exam _____

What is Your Chief Complaint? (*Reason for visit*) _____

_____

Please Check the Eye/Vision Symptoms You (or your child) Are Experiencing:

☐ Headaches	☐ Blur with Distance Tasks	☐ Blur with Near Tasks
☐ Difficulty when Driving @ Night	☐ Eyes Feel Tired with Near Tasks	☐ Eyes Feel Dry
☐ Eyes Feel Scratchy	☐ Eyes Water Excessively	☐ Eyes Burn with Computer Use
☐ Double Vision	☐ Light Sensitivity	☐ Favors One Eye
☐ Frequent Styes	☐ Red Eyes	☐ Red Rimmed Eyelids
☐ Must Hold Reading Too Close	☐ Must Hold Reading Farther Away	☐ Low Reading Endurance
☐ Loss of Attention	☐ Poor Reader	☐ Poor Comprehension
☐ Dislikes Reading	☐ Makes Copying Errors	☐ Hyperactive
☐ Learning Problems	☐ Squinting	☐ Car Sickness

Is Today's Examination Especially For: (*check all that apply*)

☐ Glasses ☐ Contact Lenses ☐ Lasik ☐ Routine Yearly Exam

☐ Eye Infection or Injury (please explain) _____

☐ Other _____

Do You Currently Wear Contact Lenses? ☐ Yes ☐ No If yes, what type/brand? _____

Do You Like Your Contact Lenses? ☐ Yes ☐ No If no, why not? _____

Do You Want to Wear Contacts? ☐ Yes ☐ No ☐ Clear ☐ Color ☐ Both

Do You Wish You Could Sleep in Your Lenses? ☐ Yes ☐ No Do You Currently Sleep in Your Lenses? ☐ Yes ☐ No

Check Any Special Eyewear Interest:

☐ Sunglasses ☐ Sport Glasses ☐ Computer Glasses ☐ Safety Glasses ☐ Other _____

Please Check Your Job or Hobby Activities:

☐ Reading	☐ Studying	☐ Computer Use	☐ Desk Work	☐ Drafting
☐ Sewing	☐ Crafts	☐ Reading in Bed	☐ Machine Operation	☐ Home Workshop
☐ Musical Instrument	☐ Piano	☐ Card Playing	☐ TV	☐ Fishing
☐ Golf	☐ Tennis	☐ Biking	☐ Swimming	☐ Flying
☐ Racquetball	☐ Scuba Diving	☐ Sky Diving	☐ Mountain Climbing	☐ Baseball/Softball
☐ Team Sport _____			☐ Other _____	

Who Should We Contact In Case of Emergency? _____ Phone (___)_____

Primary Care Physician _____

Medical Insurance Carrier _____

THANK YOU FOR CHOOSING OUR FAMILY FOR YOUR EYECARE!