Rockville Eye Center

Welcome to Our Office

In order to provide us with a better understanding of your vision care needs, please complete the following history.

Last Name: ________________________ First Name: __________________________ Date: _________________

Date of Birth: _______________ Vision Insurance: ________________ Occupation: ________________ Sex: **M** **F**

Primary Insurance Holder's Name & Birth Date & Last 4 SSN: ____

Telephone (home):_____________________ (work): ____________________________ Email: __________________

Address: ____

City: _______________ State: ____________ Zip Code: _____________ Date of Last Eye Exam: _________________

Your reason(s) for visiting our office today: (Please check appropriate items)

☐ General annual exam (no specific problem)
☐ Lost or broken eyeglasses
☐ Want new eyeglasses
☐ Want contact lenses
___soft ___rigid gas perm
___disposable ___tinted
___bifocal contact lenses
☐ Blurred distance vision

☐ Blurred near vision
☐ Eyes feel tired
☐ See spots/flashes
☐ Double Vision
☐ Light Sensitivity
☐ Headaches
☐ Problems with present contact lenses

☐ Eyes water
☐ Eyes itch
☐ Eyes feel dry
☐ Pain in eyes
☐ other (please list)
____
____
____

Lifestyle Needs

You may be a candidate for laser correction of your nearsightedness, farsightedness, or astigmatism.

Are you interested in learning about Laser Vision Correction? ☐Yes ☐No

In which activities do you participate?

Sports ____

Hobbies____

Computers (how many hours per day?)____

About your general health-past or present:

☐ High blood pressure
☐ Heart disease
☐ Diabetes
☐ Glaucoma
☐ Allergies

☐ Cataracts
☐ Lazy eyes
☐ Eye Surgery
☐ Retinal disorders
☐ Eye injuries

☐ Cancer
☐ other (please list)
____
____
____

Has anyone in your family (blood relative) had any of the above conditions? ☐**Yes** ☐**No**

If so, what relative? What condition(s)? Please list here (do not check in list above)

____

Are you allergic to any medications? ☐ **Yes** ☐ **No** If yes, please list _______________________________________

Do you use cigarettes/tobacco? ☐ **Yes** ☐ **No** Other Substance? ☐ **Yes** ☐ **No**

Are you pregnant? ☐ **Yes** ☐ **No** Alcohol? ☐ **Yes** ☐ **No**

Please list any medications you are currently taking ____

I acknowledge that I have been made aware of the HIPPA Notice of Privacy.

Signature: ____ **Date:** ____