BAUER OPTICAL EYE CARE

OUR FOCUS IS ON YOU

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Date of Birth _____ Age _____

Sex ❑ M ❑ F

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Cell Phone _____

Email Address _____

How do you prefer to be contacted?

(Indicate #1 and #2 Choice):

Home # ___ Work # ____ Cell # ____ Text ____ Email ____

Patient's SSN _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative? _____

Of not referred, how did you choose our office?

❑ Another Dr.

❑ Insurance List

❑ Saw Sign/Building

❑ Newspaper/Radio/TV

❑ Yellow Pages: Which Directory? _____

❑ Web Page: Which Website? _____

❑ Other _____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscribers Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

❑ Yes ❑ No

How will you settle your account today?

❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you....(check box if your answer is yes)

❑ work at a computer?

❑ think you might benefit from thinner, lighter lenses?

❑ have interest in a "test drive" of the latest contact lens designs

❑ spend time outdoors? How much? ____ Hrs./week

❑ have prescription sunwear?

❑ prefer not to wear your glasses at times?

❑ play any sports?

❑ have any hobbies that may require unique eyewear/lenses?

❑ have more than 1 pair of current Rx eyewear?

❑ have children?

❑ have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following ocular conditions?

❑ Blurry visions

❑ Burning

❑ Cataracts

❑ Corneal Abrasions

❑ Crossed Eye/Eye Turn

❑ Double Vision

❑ Eye Infections

❑ Eye Injury

❑ Flash of Light

❑ Floaters/Spots

❑ Glaucoma

❑ Grittiness

❑ Headaches

❑ Iritis/Uveitis

❑ Itchiness

❑ Lazy Eye

❑ Macular Degeneration

❑ Occasional Dryness

❑ Retinal Detachment

❑ Sunlight Sensitivity

❑ Tearing

❑ Trouble Seeing at Night

❑ Uncomfortable Glasses

❑ Other Eye Disorders _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

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? ❑ Yes ❑ No

If so, what medications? _____

_____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Ingumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual Weight Losses/Gains	❑	❑

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses ❑ Yes ❑ No

What kind? _____

Solutions used _____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑ _____
Cataracts	❑ _____
Corneal Problems	❑ _____
Diabetes	❑ _____
Glaucoma	❑ _____
Heart Disease	❑ _____
Lazy Eye	❑ _____
Macular Degeneration	❑ _____
Retinal Problems	❑ _____

I HAVE READ AND UNDERSTAND THE CONSENT FORM AND CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____ _____

DATED PATIENT PATIENT GUARDIAN

IF PATIENT GUARDIAN IS SIGNING, PLEASE DESCRIBE YOUR RELATIONSHIP. _____