Date____________________

Welcome to Gailmard Eye Center

Patient's name_________________________________ ¨ Mr. ¨ Mrs. ¨ Dr. ¨ Miss ¨ Ms. ¨ Rev.

Address__________________________ City______________________ State_______ Zip_________

Home Phone____________________________ Work Phone________________________________

E-mail address ____

Who referred you to our office? (Name)____

¨ Insurance listing ¨ Family member ¨ Yellow pages ¨ Physician / Eye Doctor

Patient's date of birth________________________ Social Security Number_________________________

Occupation____

Name of employer____ City_______________________

Special visual demands (work or hobbies)____

Name of spouse____

Please list any members of your household who come to our office _________________________________

____

Please circle if you have ever had any of the following: Cataracts Glaucoma Lazy Eye Diabetes

Macular degeneration Eye infections High blood pressure Allergies Do you smoke? Yes / No

List any other medical problems____

Who is your family physician?____

Have you ever had any injury or surgery to your eyes? Yes No Describe___________________________

Previous eye doctor____

Have any blood line relatives had glaucoma, or other loss of sight?______________________________

Are you allergic to any medications? Yes No (List)____

Do you presently wear glasses? Yes No How old are the glasses?___________________________

When do you wear them?____

Do you presently wear contact lenses? Yes No Hard Gas Permeable Soft Disposable

If yes, how old are the contacts?______________ If no, have you ever worn contacts? Yes No

Do you have vision care insurance? Yes No Name____

Do you have health insurance? Yes No Name and ID number___________________________________