Concord Eye Care Center OD PA

Sonnie Bryant, O.D.

WE ARE GLAD YOU ARE HERE!
TO ENSURE THE BEST SERVICE POSSIBLE,
PLEASE ANSWER THE FOLLOWING QUESTIONS.

TODAY'S DATE: _____
NAME: _____ PREFERRED: _____ DATE OF BIRTH: _____ SEX: M ☐ F ☐
STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
E-MAIL: _____ SS#: _____
HOME PHONE: _____ CELL: _____ SPOUSE'S NAME: _____
NAME/LOCATION OF PRIMARY PHYSICIAN: _____
VISION INSURANCE: _____ MEDICAL INSURANCE(S): _____ PRIMARY: _____

PLEASE FILL IN THIS PORTION ONLY IF THE PATIENT IS UNDER 18 YEARS OLD:
Mother's Name: _____ *Date of Birth:* _____ *SS#:* _____
Mother's Employer: _____ *Work Phone:* _____
Mother's Insurance Company: _____
Mother's Address if Different: _____

Father's Name: _____ *Date of Birth:* _____ *SS#:* _____
Father's Employer: _____ *Work Phone:* _____
Father's Insurance Company: _____
Father's Address if Different: _____

In the event of an emergency, contact: _____
Relationship: _____ *Phone:* _____ *Alternate Phone:* _____

IF YOU ARE NEW TO OUR OFFICE, HOW DID YOU HEAR ABOUT US?

☐ Another Doctor _____ ☐ Saw Building/Sign ☐ Website
☐ Insurance Listing ☐ Magazine ☐ Friend/Family Member _____
☐ Yellow Pages ☐ Newspaper ☐ Other _____

DO YOU HAVE ANY OF THE FOLLOING MEDIAL CONDITIONS? Please check all that apply.

☐ Stroke/ Vascular Disease ☐ Cancer ☐ Skin eczema/Rash
☐ Diabetes ☐ Seizures ☐ Thyroid Disease
☐ High Blood Pressure ☐ Lung Disease/Asthma ☐ Arthritis
☐ High Cholesterol ☐ Headaches/Migraines ☐ Weight loss/Gain
☐ Heart Disease ☐ Pregnant/Breast Feeding ☐ Autoimmune _____
☐ Kidney/Bladder ☐ Psychiatric ☐ Other _____

CURRENT MEDICATIONS? YES ☐ NO ☐ PLEASE LIST: (INCLUDE OVER THE COUNTER, HERBS, VITAMINS AND BIRTH CONTROL) _____
_____

DRUG ALLERGIES? YES ☐ NO ☐ PLEASE LIST: _____
DO YOU USE: TOBACCO PRODUCTS? YES ☐ NO ☐ ALCOHOL? YES ☐ NO ☐ RECREATIONAL DRUGS? YES ☐ NO ☐
IF YES, WHAT TYPE? FREQUENCY? HOW LONG? _____

PLEASE FILL OUT BACK ALSO.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING EYE CONDITIONS? Please check all that apply.

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blindness
- ☐ Turned/Crossed Eyes
- ☐ Dry Eyes/Allergies
- ☐ Lazy Eye
- ☐ Retinal Detachment
- ☐ Eye Surgery
- ☐ Eye Injury
- ☐ Other_____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING DISEASES? Please check all that apply.

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Disease
- ☐ Blindness
- ☐ Turned/Crossed Eyes
- ☐ Lazy Eye

WHAT ARE THE REASONS FOR TODAY'S APPOINTMENT? Please check all that apply.

- ☐ Sudden Loss of Vision
- ☐ Distance Blurred Vision
- ☐ Near Blurred Vision
- ☐ Frequent Headaches
- ☐ Frequent Eyestrain
- ☐ Double Vision
- ☐ Eye turning in/out
- ☐ Watering/Tearing Eyes
- ☐ Red Eye
- ☐ Eyes Itching/Allergies
- ☐ Eye Pain
- ☐ Burning/Dry Eyes
- ☐ Seeing Flashes of Light
- ☐ Contact Lens Discomfort
- ☐ Floating Spots in Vision
- ☐ Discharge from Eyes
- ☐ Matted Eyelids
- ☐ Unusual Light Sensitivity
- ☐ Foreign Matter in Eyes
- ☐ Other_____
- ☐ Annual/Routine Exam

LIFESTYLE QUESTIONS?

Who is your employer? _____
What is you occupation? _____
Do you have trouble with your current glasses? _____
Do you prefer not to wear your glasses at times? _____
Do you have more than one pair of prescription glasses? _____
Do you think you might benefit from thinner/lighter lenses? _____
Are your eyes sensitive to sunlight or bright lights? _____
Do you have prescription sunglasses? _____
Do you spend time or work outside? _____Doing what? _____
Do your eyes tire quickly while reading? _____
Do you use a computer? _____ How much? _____
Do you have trouble with night time driving? (Glare) _____
Are you interested in Laser Vision Correction? _____
Do you have other family members in need of eye care? _____
Are you involved in activities that may put your eyes in danger? _____If so, what? _____

CONTACT LENS QUESTIONNAIRE. Please check all that apply.

- ☐ I am not interested in contact lenses.
- ☐ I have never worn contacts, but I am interested in my options.
- ☐ I am not satisfied with the vision of my current contact lenses.
- ☐ I am not satisfied with the comfort of my current contact lenses.
- ☐ I currently wear contacts.

If you wear contacts, what type? _____ What solutions? _____
Do you sleep in your lenses? YES ☐ NO ☐ How often? _____
Replacement Schedule? ☐ Daily ☐ Two-Weeks ☐ Monthly ☐ Quarterly ☐ Yearly

THANK YOU!