MODERNEYES OPTICAL

Patient #____________________

Today's Date: ____/_____/______

Patient Information

First Name______________ Last Name________________ Preferred Name_____________ Birth date ____/____/______ ☐M ☐F

Address____ City______________________________ State________ ZIP__________

Mobile/Home Phone (_____)______________________ Email____

Employer___________________________________ Occupation/Grade_____________________________________

Parent/Guardian (if under 18)__________________________ Relationship: ☐Father ☐Mother ☐Guardian Phone(_____)________________

Emergency Contact_____________________________ Relationship_____________________ Phone(_____)________________

Primary Care Provider___________________________ Preferred Pharmacy: ____________________

Medicare / Medicaid? ☐Yes ☐No

Medical & Ocular History

Reason for today's visit:____

Do you wear: **Glasses** ☐ Yes ☐ No If yes, age of current glasses____________________

Contact lenses ☐ Yes ☐ No If yes, what brand___________________ Prescription: Right Eye___________ Left Eye___________

How many hours on an average day do you spend on digital devices?_______________

Have you ever had any of the following conditions? (*Please check all that apply, must select at least one, list any others*)

☐ Glaucoma	☐ Retinal Tear/Detachment	☐ Eye Surgery (incl Laser)	☐ Thyroid Problems	☐ Currently Pregnant
☐ Cataracts	☐ Strabismus (eye turn)	☐ Double Vision	☐ Heart Disease	☐ Other:_______________
☐ Macular Degeneration	☐ Amblyopia (Lazy Eye)	☐ Frequent Headaches	☐ Cancer	☐ Other:_______________
☐ Retinal Disease	☐ Eye Injury/Trauma	☐ Diabetes	☐ Rheumatoid Arthritis	
☐ Uveitis/Inflammation	☐ Blindness	☐ High Blood Pressure	☐ Asthma	☐ **NONE OF THE ABOVE**

Eye Surgeries: ____

Some medications have ocular side effects, please list all medications/Supplements/Eye Drops you take:

____

____

Allergies: ☐ NONE ☐ Latex ☐ Iodine ☐ Medications (list including reaction)________________________________

Personal History: **Smoker**: ☐ Current ☐ Previous ☐ Never **Drugs**: ☐ Sometimes ☐ Previous ☐ Never **Alcohol**: ☐ Frequent ☐ Occasional ☐ Never

Does any immediate family member have a history of any of the following conditions?

☐ Glaucoma	☐ Diabetes	☐ High Blood Pressure
☐ Cataract	☐ Strabismus (Crossed Eyes)	☐ Cancer
☐ Macular Degeneration	☐ Amblyopia (Lazy Eye)	☐ **NONE OF THE ABOVE**
☐ Retinal Tear/Detachment	☐ Blindness	

Signature of Patient (Parent/Guardian if minor)____ Date ______/_____/_________

Office Use: Date________ ☐ Changes ☐ No Changes Initial_______

Date________ ☐ Changes ☐ No Changes Initial_______

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