Welcome to **20/Twenty Optical and Eye Care**

Dr. Jeffrey W. Luther, Optometrist

PATIENT INFORMATION

Last Name_____ **First Name**_____ **M.I.**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Email_____

Date of Birth_____ **SSN**_____ **Marital Status**_____ **Gender**_____

Occupation_____ **Employer**_____

Emergency Contact_____ **Phone**_____

Primary Vision Insurance Coverage_____ **Secondary Coverage**_____

How did you hear about 20/20 Optical and Eye Care?_____

EYE HISTORY

Date of Last Eye Exam_____ **Dilated? Yes / No**

Do you wear Glasses? Yes / No How old are they?_____ **Use: Full Time / Reading Only / Distance Only**

Do you wear Contacts? Yes / No Type_____ **Solution Used**_____

Success wearing contacts? Poor Fair Good

Please circle yes or no if you are *recently experiencing significant*...

Blurred Vision- Distance	YES	No	Double Vision	YES	No	Red Eyes	YES	No
Blurred Vision – Near	YES	No	Dry Eyes	YES	No	Sandy/ Gritting Feeling	YES	No
Bloodshot Eyes	YES	No	Flashes or Floaters	YES	No	Seeing Halos	YES	No
Burning Eyes	YES	No	Headaches	YES	No	Sudden Vision Loss	YES	No
Color Vision – poor	YES	No	Itching Eyes	YES	No	Twitching Eyelid	YES	No
Crossed Eyes	YES	No	Light Sensitive	YES	No	Watery Eyes	YES	No
Discharge from Eyes	YES	No	Night Vision – poor	YES	No	Other:		

Have you ever had or been told you have:

Eye Injury - Explain	YES	NO	Glaucoma	YES	NO
Eye Surgery – Explain	YES	NO	Macular Degeneration	YES	NO
Cataracts	YES	NO	Other:	YES	NO

MEDICAL HISTORY

Your Primary Physician_____ Phone number _____

Date of Last Physical_____ Overall Health: Poor Fair Good Excellent

Medications (including vitamins, eye drops, birth control pills) _____

_____

Are you allergic to any medications? Which?_____

Review of Systems

- Diabetes or pre-diabetes? Yes / No Last known fasting blood sugar:_____ Hba1c _____
- High blood pressure? Yes / No Last blood pressure reading: _____ / _____
- High Cholesterol? Yes / No Latest readings:_____

Social History (This is strictly confidential. Please check if you wish to verbally discuss with Dr. Luther. _____)

- Do you use tobacco products? Yes / No
- Do you drink alcohol? Yes / No
- Do you use illegal drugs? Yes / No
- Are you pregnant? Yes / No
- Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Please circle yes or no if you have a *reoccurring medical problem* with the following ...

Allergic/Immunologic -- Hay Fever, Medicine	YES	NO	Genitourinary-- Genitals, Kidneys, Bladder	YES	NO
Constitutional Symptoms -- Fever, Weight Loss	YES	NO	Hematologic/Lymphatic -- Anemia, Bleeding Problems, Swelling	YES	NO
Cardiovascular -- Heart Pain, High Blood Pressure, Vascular	YES	NO	Integumentary -- Skin, Breast	YES	NO
Ear, Nose, Mouth, Throat -- Allergies, Hay Fever, Sinus, Chronic Cough, Dry Mouth, Chronic Ear Infections	YES	NO	Musculoskeletal -- Arthritis, Rheumatoid Arthritis, Joint Pain	YES	NO
Endocrine -- Diabetes, Thyroid problems, Glands	YES	NO	Neurological -- Headaches, Seizures	YES	NO
Gastrointestinal -- Diarrhea, Constipation, Ulcers	YES	NO	Psychiatric / Mental Health -- Nervous Disorders, Depression	YES	NO
Other:			Respiratory -- Asthma, Short Breath, Emphysema, Lung Cancer	YES	NO

Family History – Is there anyone in the family who has/had...

Blindness		High Blood Pressure		Glaucoma		Multiple Sclerosis	
Cataracts		Lazy Eye		Cancer		Other:	
Corneal Problems		Macular Degeneration		Heart Attack/ Stroke		Other:	
Diabetes		Retinal Problems		Bleeding Disorders		Other:	

Fee Policy – Fees are collected when service is rendered. 50% of the material costs are collected when order is placed and the balance is due when material is dispensed.

Patient Signature_____ Date_____

History Reviewed by Doctor _____ Date_____