MAINE OPTOMETRY, P.A.

PATIENT: First _____ Last _____ M.I. ____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ E-mail _____

Birth Date _____ Age _____ Social Security #: _____

OCCUPATION _____ Employer _____

Name of previous eye doctor _____ Approximate date of last visit _____

Primary Care Physician _____ Insurance _____

STUDENTS: School _____ Teacher _____ Grade _____

IF UNDER 18: Father's name _____ Mother's name _____

YOUR OCULAR HISTORY – Past & Present

Do you wear eyeglasses? ☐ No ☐ Yes: ☐ distance ☐ near For what? _____

Do you wear contact lenses? ☐ No ☐ Yes: ☐ soft ☐ hard (gas permeable) Brand: _____

Have you worn contacts in the past? ☐ No ☐ Yes: ☐ soft ☐ hard (gas permeable) How long ago? _____

PLEASE CHECK ALL THAT APPLY:

__ Blurred Vision: __ Distance __ Near □ Right □ Left

__ Watery Eyes
__ Itchy Eyes
__ Dry Eyes
__ Eyestrain
__ Eye Pain
__ Double Vision
__ Frequent Loss of Place While Reading
__ Poor Reading Comprehension
__ Fluctuating Vision
__ Optic Neuritis
__ Iritis / Uveitis
__ Floating Spots
__ Shimmering / Geometric Lights
__ Flashing Lights
__ Reduced Color Vision
__ Black Outs / Vision Loss
__ Droopy Eyelids: □ Right □ Left

__ History of a Turning Eye: □ Right □ Left
__ Cataracts: □ No □ Yes
__ Surgery to Straighten an Eye: □ Right □ Left
__ Cataract Surgery? □ Right □ Left
__ Patching an Eye: □ Right □ Left
__ Glaucoma: How long? _____
__ Eye Injury: What? _____
__ Macular Degeneration: How Long? _____

Please list any additional information about your eyes: _____

_____

Notice of Privacy Practice

I acknowledge that I was offered a copy of MAINE OPTOMETRY P.A. Notice of Privacy Practices

Signature: _____ *Date:* _____

PLEASE COMPLETE THE BACK OF THIS FORM SO WE CAN BETTER SERVE YOUR EYE CARE & EYEWEAR NEEDS

PLEASE CHECK ALL THAT APPLY TO *YOUR* PERSONAL HEALTH

CARDIOVASCULAR: ADDITIONAL INFO

- Chest Pain ☐ _____
- Heart Disease ☐ _____
- High Blood Pressure ☐ _____
- High Cholesterol ☐ _____
- Irregular Heartbeat ☐ _____
- Pacemaker ☐ _____

Other _____

CONSTITUTIONAL:

- Chronic Fatigue ☐ _____
- Frequent Dizziness ☐ _____

Other _____

EAR, NOSE & THROAT:

- Chronic Sinus Infection ☐ _____
- Chronic Ear Infection ☐ _____
- Hearing Loss ☐ _____

Other _____

ENDOCRINE:

- Diabetes ☐ Type I ☐ Type II
  - How long? _____
  - Average blood sugar: _____ Fasting: _____
  - HbA1c reading: _____
- Thyroid Disorder ☐ _____

Other _____

GASTROINTESTINAL:

- Crohn's Disease ☐ _____
- Irritable Bowel ☐ _____

Other _____

GENITOURINARY:

- Kidney Disorder ☐ _____
- Menopausal ☐ _____
- Pregnant ☐ _____
- Prostate Disorder ☐ _____

Other _____

HEMATOLOGY/ ONCOLOGY:

- Cancer ☐ Type: _____
  - Approximate date of diagnosis: _____
- Addt'l Info _____

IMMUNOLOGIC: ADDITIONAL INFO

- Lupus ☐ _____
- Multiple Sclerosis ☐ _____
- Sarcoidosis ☐ _____

Other _____

INTEGUMENTARY:

- Eczema ☐ _____
- Rosacea ☐ _____

Other _____

MUSCULOSKETAL:

- Fibromyalgia ☐ _____
- Muscular Dystrophy ☐ _____
- Rheumatoid Arthritis ☐ _____
- Trauma/Injury ☐ _____
  - What/When? _____

Other _____

NEUROLOGICAL:

- Headaches ☐ _____
- Migraines ☐ _____
- Numbness/Tingling ☐ _____
- Stroke ☐ _____

Other _____

PSYCHIATRIC:

- Anxiety ☐ _____
- Dementia ☐ _____
- Depression ☐ _____

Other _____

RESPIRATORY:

- Asthma ☐ _____
- Emphysema ☐ _____
- Persistent Cough ☐ _____
- Shortness of Breath ☐ _____
- Tuberculosis ☐ _____
- Do You Smoke? ☐ _____
  - If yes, for how long? _____

Other _____

FAMILY HISTORY **who was diagnosed?**

- Blindness ☐ _____
- Cataracts ☐ _____
- Color Vision Problems ☐ _____
- Glaucoma ☐ _____
- Macular Degeneration ☐ _____
- Misaligned Eyes ☐ _____
- Retinal Tear/Hole/Detach ☐ _____

MEDICATIONS:

ALLERGIES:

SIGNATURE: _____ **DATE:** _____