NEW PATIENT

Name: _____ (Nickname):_____ DOB: _____
Address: _____ Phone: _____
Insurance: _____ Responsible Party: _____
Last four digits of SS#:_____ Primary Care Physician:_____

Last eye exam:_____ Previous Eye Dr.:_____

Eye and Medical History

Do you or anyone in your immediate family have a history of the conditions listed below? Check all that apply.

	YOU	RELATIVE
Allergies(seasonal)	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Diabetes	_____	_____
Digestive Conditions	_____	_____
Ear/Nose/Throat	_____	_____
Blood diseases	_____	_____
Immune Conditions	_____	_____
Skin Problems	_____	_____
Muscle/Joint Conditions	_____	_____

	YOU	RELATIVE
Neurological Conditions	_____	_____
Breathing Problems	_____	_____
Thyroid Problems	_____	_____
Glaucoma	_____	_____
Macular Degeneration	_____	_____
Amblyopia (Lazy eye)	_____	_____
Crossed Eyes	_____	_____
Retina Detach/Tear	_____	_____
Cataracts	_____	_____
Other:_____	_____	_____

Please list current medications and/or vitamins:
_____
_____
Medications you are **allergic** to: _____

Are you experiencing headaches? YES NO If yes, how often?_____

Do you smoke? YES NO QUIT (when: _____)

Alcohol consumption NEVER OCCASIONALLY 1-2 PER DAY >2 PER DAY

For women only: Are you pregnant or nursing? YES NO

Do you currently wear contacts? YES NO Do you want to be fit with contacts? YES NO
(*If yes please keep reading)*
A yearly contact lens evaluation is necessary to review and buy new contact lenses. The contact lens exam **is not** part of the comprehensive eye health or refractive vision test examination. Contact lens patients require additional testing, time measuring and monitoring to evaluate the design and fit of their current lenses, the health of the eye as it relates to contacts or in the case of a new wearer, their suitability to wear contacts. The contact lens fee varies with complexity of the lens design and diagnostic fitting time. Insurance or vision benefit plans may contribute an allowance.

How did you choose our office? Location Online Newspaper Ad Insurance Plan
Family/Friend Referral: _____ Other:_____

I acknowledge that I was offered a copy of Fowle Eye Care Associates, PLC. Notice of Privacy Practices (copy in the waiting room, if you would like one to keep…please let us know)

Signature:_____ Date:_____