Tri State Optical Center

Welcome to Our Office!

Kate Landis, OD/ Dan Landis, OD/ Ashley Brooks, OD/ Christina Thompson, OD

Today's Date____/____/_____ SSN _____

Last Name_____ First Name_____ MI____ Sex M F Age____ DOB____/____/_____

Street Address_____ City_____ State_____ Zip_____

Phone: (Primary)_____-_____-_____ Text OK? Y/N (Secondary)_____-_____-_____ Text OK? Y/N

Occupation_____ Employer (or school)_____

Email: _____ Emergency contact:_____

Medical History Questionnaire

Patient Eye History (Check all that apply)

Date of Last Eye Exam _____

Do you experience any of the following:

⬛ Blurry Vision ⬛ Burning ⬛ Double Vision

⬛ Floaters ⬛ Tearing ⬛ Light Flashes

⬛ Eye Turn ⬛ Headaches ⬛ Itching

⬛ Dryness ⬛ Discharge

Have you been diagnosed/treated for the following:

⬛ Cataracts ⬛ Eye Infection ⬛ Glaucoma

⬛ Iritis/Uveitis ⬛ Lazy Eye ⬛ Eye Trauma

⬛ Retinal Detachment ⬛ Macular Degeneration

Other_____

Ocular Surgeries_____

Are you planning on getting new Glasses today?

⬛ Yes ⬛ No

Do you currently wear contact lenses? ⬛ Yes ⬛ No

What Kind? _____

Are you satisfied with your current contacts?

⬛ Yes ⬛ No

Patient Medical History

Family Physician_____

Date of Last Physical _____/_____/_____

Current Medication (Have List? Give to front desk)

_____

_____

_____

Allergies to Medications ⬛ Yes ⬛ No

If yes, please explain: _____

_____

Have you been diagnosed/treated for the following:

⬛ Asthma ⬛ Arthritis ⬛ High Blood Pressure

⬛ Cancer ⬛ Cholesterol ⬛ Heart Disease

⬛ Diabetes Recent A1C & Blood Sugar_____

⬛ Other: _____

Are you Pregnant or Nursing? € Yes € No

Family Medical/Eye History (Check all that apply)

Relationship

⬛ Blindness _____

⬛ Glaucoma _____

⬛ Lazy Eye _____

⬛ Macular Degeneration _____

⬛ Retinal Detachment _____

⬛ Diabetes _____

Privacy Agreement*:

I consent to the use and disclosure of my health information for purposes of treatment, payment and health care operations. I understand that if my insurance does not cover the charges for services and/or materials, I am responsible for the amount due.

Signature_____

_____

(Relationship to Patient, if Patient under 18) Print Name

*Notice of Privacy Practices can be furnished upon request.