

# EK Optometric Associates

Dr. Kim B. Even

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Work Phone \_\_\_\_\_

\_\_\_\_\_ **Cell Phone** \_\_\_\_\_

\_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security – (Last 4 digits) \_\_\_\_\_

Occupation \_\_\_\_\_ E-mail address \_\_\_\_\_

Vision Insurance Carrier \_\_\_\_\_ Health Insurance Carrier \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Primary Care Physician Phone \_\_\_\_\_

Sports/Hobbies \_\_\_\_\_ Referred by \_\_\_\_\_

Date of Last Eye Exam (approx) \_\_\_\_\_ Previous Eye Doctor \_\_\_\_\_

Reason For Visit \_\_\_\_\_

## Do you have a problem with:

Eye itching      Yes \_\_\_ No \_\_\_      Blurry vision      Yes \_\_\_ No \_\_\_

Pain in eyes      Yes \_\_\_ No \_\_\_      Double vision      Yes \_\_\_ No \_\_\_

Dry eyes      Yes \_\_\_ No \_\_\_      Floaters      Yes \_\_\_ No \_\_\_

Watering      Yes \_\_\_ No \_\_\_      Flashes of light      Yes \_\_\_ No \_\_\_

Redness      Yes \_\_\_ No \_\_\_      Severe or abnormal headaches      Yes \_\_\_ No \_\_\_

## Ocular History

    Eyeglass wear:      Current \_\_\_ Previous \_\_\_ Never \_\_\_

    Contact Lens wear:      Current \_\_\_ Previous \_\_\_ Never \_\_\_

## Are You Interested in Obtaining Contact Lenses or Eyeglasses?

**Ocular History – Family**      Glaucoma: Yes \_\_\_ No \_\_\_

**Are You Interested in Laser Vision Correction?**      Yes \_\_\_ No \_\_\_

## Health History

    Major Illnesses in the family (parents and siblings only)?      Yes \_\_\_ No \_\_\_

Describe: \_\_\_\_\_

## Health Status

    Major Illnesses personally?      Yes \_\_\_ No \_\_\_

Describe: \_\_\_\_\_

**Do You Smoke?**      Yes \_\_\_ No \_\_\_

**Medications** (name and condition.): \_\_\_\_\_

**Allergies** (drug, environmental): \_\_\_\_\_