OPTI-CARE

Today's Date: _______________

Patient's name: ____ Date of birth:________________

If minor, parent's name: ____ Gender: ☐ M ☐ F

Address: ____

City:______________________________ State: _________ Zip:__________ Last 4 digits of SS#: ___________

Cell: ___________________________ Home: _________________________ Work: ______________________

May we contact you by: ☐ Text ☐ Email ____

Employer: _____________________________________ Occupation: _________________________________

Name of primary care physician: ____

Major medical insurance:____

Primary insured: ___________________________________ Relationship to insured: __________________

Last 4 digits of SS# for primary: _____________ Primary member DOB: _________________________

Do you wear glasses? ☐ Y ☐ N Do you wear contact lenses? ☐ Y ☐ N

Review of systems		Ocular History:		Previous eye surgeries	
Seasonal allergies	☐ Y ☐ N	Blurred vision	☐ Y ☐ N	Cataract	☐ Y ☐ N
Rheumatoid arthritis	☐ Y ☐ N	Cataracts	☐ Y ☐ N	Retinal detachment	☐ Y ☐ N
High blood pressure	☐ Y ☐ N	Strabismus	☐ Y ☐ N	Trauma	☐ Y ☐ N
Heart disease	☐ Y ☐ N	Optic nerve disease	☐ Y ☐ N	Muscle surgery	☐ Y ☐ N
Cholesterol	☐ Y ☐ N	Double vision	☐ Y ☐ N	LASIK/PRK	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Eye infections	☐ Y ☐ N	Foreign body removal	☐ Y ☐ N
Gastrointestinal	☐ Y ☐ N	Eye injury/trauma	☐ Y ☐ N		
Cancer	☐ Y ☐ N	Flashers/floaters	☐ Y ☐ N	Family history	
Endocrine/thyroid	☐ Y ☐ N	Glaucoma	☐ Y ☐ N	Blindness	☐ Y ☐ N
Ear/nose/throat	☐ Y ☐ N	Macular degeneration	☐ Y ☐ N	Glaucoma	☐ Y ☐ N
Seizures	☐ Y ☐ N	Retinal disease	☐ Y ☐ N	Diabetes	☐ Y ☐ N
Urinary/STD	☐ Y ☐ N	Retinal detachment	☐ Y ☐ N	Cataracts	☐ Y ☐ N
Blood/Lymph nodes	☐ Y ☐ N	Amblyopia	☐ Y ☐ N	Macular degeneration	☐ Y ☐ N
Psychiatric	☐ Y ☐ N	Dry eyes	☐ Y ☐ N	Keratoconus	☐ Y ☐ N
Respiratory	☐ Y ☐ N	Iritis	☐ Y ☐ N	Retinal detachment	☐ Y ☐ N
Multiple sclerosis	☐ Y ☐ N	Keratoconus	☐ Y ☐ N		
		Diabetic retinopathy	☐ Y ☐ N		

Do you smoke? ☐ Y ☐ N ☐ Quit

Medications: ____

____

Allergies: ____

Reviewed/Updated _______________ _______________ ________________

Date Date Date