VILLAGE EYE CARE, P.C. STEVEN A. MARKOW, O.D., F.A.A.O.

Date:_____ **OPTOMETRIC HISTORY** **Updated:**_____

Welcome to the Office

In order to provide you with the best possible eye care, please answer the following questions:

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TELEPHONE #: _____

CELL PHONE #: _____

E-MAIL: _____

IN CASE OF EMERGENCY CONTACT: _____

PHONE #: _____ **RELATIONSHIP:** _____

****

OCCUPATION: _____

EMPLOYER: _____

WORK TELEPHONE #: _____

BIRTHDATE: _____/_____/_____

AGE: _____ **GENDER: M** ____ **F**____

SOCIAL SECURITY #: xxx- xx-_____

DO YOU HAVE HEALTH INSURANCE ?: YES ____ **NO** ____

NAME OF PLAN: _____

IS TODAYS VISIT UNDER WORKMAN'S COMPENSATION INSURANCE: Y___ **N** ___

FIRST VISIT TO THE OFFICE ? YES ___ **NO**___

WHOM MAY WE THANK FOR REFERRING YOU ? _____

HOW DID YOU HEAR ABOUT THE OFFICE ? _____

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MEDICAL & EYE HISTORY

REASON FOR TODAY'S VISIT: _____

DATE OF LAST EYE EXAM: _____ **BY WHOM ?** _____

DATE OF LAST MEDICAL EXAM: _____ **BY WHOM ?** _____

CONTACT LENS WEARER ? NO____ **YES** _____ **TYPE ?** _____ **COMPUTER USE ? YES** ____ **NO** ____

DO YOU HAVE SPECIAL VISION NEEDS ? _____

Please Check The Appropriate Box	You	Your Family
Eye Injury ?		//////////////
Eye Disease or Surgery ?		
Cataracts ?		
Glaucoma ?		
Blindness or Macular Degeneration		
Retinal Detachment?		
Crossed Eyes / Lazy Eyes ?		
**********	*****	********
High Blood Pressure ?		
Diabetes ?		
Heart Disease or Stroke ?		
Cancer or Tumors ?		
Asthma or Respiratory Disease ?		
Thyroid ?		
AIDS, or HIV Positive test ?		

OTHER:

Cigarette / Tobacco use: Y N Alcohol use: _____

Do you have an Advance Directive for health care?: _____

Medications:

_____

_____

Allergies to Medications:

_____

_____

Dr.'s initials:_____