WELCOME TO:

Michael S. Marvin • Optometrist
David B. Pelowski • Optometrist
Daniel B. Clayton • Optometrist

Today's Date: ____________________

Name ____________________________ D.O.B. ______________

Social Security # ______________________________________

Address ____

City _________________________ Zip Code ____________

Phone (H) ___________________ (W) __________________

Employer (or School) ___________________________________

Occupation (or Grade) __________________________________

Spouse (or Parent's) Name _______________________________

Spouse (or Parent's) Occupation __________________________

How did you first hear about our office? ___________________

☐ Friend or Relative? ___________________________________

☐ Another Health Care Practitioner? ______________________

☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Internet

Do you have family members in need of eyecare? ☐ Y ☐ N

How will you settle your account today? ☐ Cash ☐ Credit

Do you participate in a flexible spending account? ☐ Y ☐ N

Insurance coverage: Please check all that apply

☐ Blue Cross/Blue Shield ☐ Medicare ☐ MN Care
☐ Vision Service Plan ☐ Senior Gold ☐ Blue Plus
☐ Medical Assistance ☐ Medica ☐ UCare
☐ Other ____

EYEWEAR AND VISION REQUIREMENTS

Do you . . .

....Engage in activities or hobbies that have special visual requirements? ☐ No ☐ Yes
....Work up close for long periods? ☐ No ☐ Yes
....Work at a computer for long periods? ☐ No ☐ Yes
....Spend a lot of time outdoors? ☐ No ☐ Yes
....Have problems with bright sunlight? ☐ No ☐ Yes
....Have problems with glare or reflections? ☐ No ☐ Yes
....Wear bifocals, trifocals, or progressive lenses? ☐ No ☐ Yes
....Wear sunglasses? ☐ No ☐ Yes
....Want information on thinner, lighter lenses? ☐ No ☐ Yes

Patient or Guardian Signature ______________________________

Doctor's Signature _______________________________________

PERSONAL EYE INFORMATION

What is the main reason for today's visit?

☐ Checkup ☐ Problem ________________________

Last Eye Exam ________________ Where _____________

Do you currently wear glasses? ☐ No ☐ Yes

If not, have you in the past? ☐ No ☐ Yes

Do you currently wear contact lenses? ☐ No ☐ Yes

What kind? _______________ Solution used _____________

If not, have you in the past? ☐ No ☐ Yes

Please check any eye problems that apply to you:

☐ Glaucoma ☐ Headaches ☐ Sensitivity to Light
☐ Cataracts ☐ Eyestrain ☐ Glare or Reflection
☐ Macular Degeneration ☐ Blurry (Distance) ☐ Spots or Floaters
☐ Other Eye Disease ☐ Blurry (Near) ☐ Flashes of Light
☐ Eye Surgery ☐ Reading Problems ☐ Dryness
☐ Eye Injury ☐ Trouble with near work ☐ Tearing
☐ Lazy Eye ☐ Trouble seeing at night ☐ Itchy Eyes
☐ Double Vision ☐ Sudden Vision Loss ☐ Burning
☐ Redness

PERSONAL MEDICAL INFORMATION

Family doctor ___________________________________

Last time seen ___________________________________

Current medications ☐ No ☐ Yes ____________________

____

Allergies ☐ No ☐ Yes ____________________________

Previous operations ☐ No ☐ Yes ____________________

Do you use tobacco? ☐ No ☐ Yes, Alcohol? ☐ No ☐ Yes

Other substances? ☐ No ☐ Yes

Please check any conditions or systems you have problems with:

☐ Diabetes ☐ Respiratory ☐ Musculoskeletal
☐ Heart Disease ☐ Ears/Nose/Throat ☐ Arthritis
☐ High Blood Pressure ☐ Cancer ☐ Gastrointestinal
☐ Psychological / Mental ☐ Integumentary (Skin) ☐ Nervous
☐ Endocrine (Glands) ☐ Asthma ☐ Genitourinary
☐ Blood / Lymphatic ☐ Cardiovascular ☐ Allergic / Immune

FAMILY MEDICAL HISTORY

			Relation
Glaucoma	☐ No	☐ Yes	______________
Cataract	☐ No	☐ Yes	______________
Macular Degeneration	☐ No	☐ Yes	______________
Other Eye Problems	☐ No	☐ Yes	______________
Diabetes	☐ No	☐ Yes	______________
Heart Disease	☐ No	☐ Yes	______________
High Blood Pressure	☐ No	☐ Yes	______________
Other	☐ No	☐ Yes	______________