WELCOME TO OUR OFFICE

Dr. Michelle Lamb
Therapeutic Optometrist

Date________________________

Mrs. Ms. Miss Mr. Dr. Rev.

Patient Name____ Date of Birth______________________Age___________

Address____City______________________State______________Zip__________

Home Phone_______________________Cell Phone_________________________ Work Phone____________________________

SS#_________-______-___________ Medicare Number______________________

Occupation ________________________________Employer______________________Spouses Name______________________

If student, Grade_____________School_______________________________Fathers Name________________________________

Hobbies____Mothers Name______________________________

Purpose of Todays Visit____

Date of Last Eye Exam_______________________________Previous Eye Doctor____

Other Family Members at Home:

Name ____________________________ *Age* _______ *Name* ___________________________________ *Age* _________

Name ____________________________ *Age* _______ *Name* ___________________________________ *Age* _________

Name ____________________________ *Age* _______ *Name* ___________________________________ *Age* _________

How did you find out about our office? Referral from other Dr. Sign Phone Book Insurance

Relative _________________________Friend_________________________Other____________________________

Whom may we thank for this referral?____

Method of Payment: Cash Check Visa / MC / Discover VSP American Express Debit Card

HEALTH HISTORY

Name of family physician____Date of Last Exam_____________

Circle any medical conditions that may apply to **you**:

Diabetes *MS* *High Blood pressure* *Allergies* *Cancer*
Heart Disease *Parkinsons* *Asthma* *Thyroid Disease* *Other*______________________
Cholesterol *Alzheimers* *Headaches* *Arthritis* ***Drug Allergies:*** ________________

Names of medications:____

Circle any medical conditions that apply to your **family**:

Diabetes *High Blood Pressure* *Arthritis*
Heart Disease *Thyroid* *Other*__________________________

Circle any eye conditions that apply to **you**:

Distance Blur *Cataract* *Crossed eyes* *Light Sensitivity* *Tearing Eyes*
Near Blur *Glaucoma* *Lazy Eye* *Burning/Redness* *Itching*
Floaters *Eye Injury* *Patching/Vision Therapy* *Headaches* *Macular Degeneration*
Flashing Lights *Double Vision* *Eye Surgery* *Dry Eye* *Eye Infections*

Circle any eye conditions that occur in your **family**:

Cataract *Retinal Detachment* *Macular Degeneration* *Crossed eyes* *Thyroid*
Glaucoma *Lazy Eye* *Blindness* *Other*________________________

CONTACT LENS HISTORY

Are you interested in Contact Lenses? *Yes* *No* Have you worn contact lenses? *Yes* *No*

Type of lenses worn?_____________________________ Any problems with your contacts? *Yes* *No*

If yes, what problems?____