

DR. FRED SLATER, OPTOMETRIST
“THANK YOU FOR COMING IN!”

“FOR OUR NEW PATIENTS,” WE APPRECIATE THE OPPORTUNITY TO SERVICE YOUR EYECARE NEEDS. PLEASE HELP US BY COMPLETING THE FOLLOWING INFORMATION SHEET.

“FOR OUR PREVIOUS PATIENTS,” WELCOME BACK! PLEASE COMPLETE THE FOLLOWING INFORMATION SHEET SO WE CAN VERIFY YOUR MOST CURRENT INFORMATION.

1. LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____ AGE: _____
2. ADDRESS: _____
3. CITY: _____ STATE: _____ ZIP: _____
4. CELL PHONE: _____ ALTERNATE PHONE: _____ EMAIL: _____
5. OCCUPATION: _____ EMPLOYER: _____
6. HOW WERE YOU REFERRED TO US? _____
7. HOW LONG HAS IT BEEN SINCE YOUR LAST EXAMINATION? _____
8. WHAT INSURANCE ARE YOU COVERED BY? _____ MEMBER ID # _____
9. MY EXAM IS FOR (CHECK ALL THAT APPLY): ROUTINE EXAM GLASSES SUNGLASSES CONTACT LENSES
 "REFRACTIVE SURGERY OCCUPATIONAL EYEWEAR SPORTS EYEWEAR
10. WOULD YOU LIKE TO LEARN MORE ABOUT LASIK SURGERY? YES NO
11. MY CHIEF VISUAL COMPLAINT IS: _____
12. IS PROTECTING YOUR EYES FROM UV RAYS IMPORTANT TO YOU? YES NO
13. ON AVERAGE, HOW MUCH TIME PER DAY DO YOU SPEND OUTDOORS IN DAYLIGHT? NONE 30-60 MIN 1-2 HRS "2+HRS
14. MY HOBBIES INCLUDE: RACQUETBALL TENNIS GOLF SKIING FISHING SEWING COMPUTERS
 BOATING OTHER _____
15. DO YOU UTILIZE A COMPUTER AT HOME OR WORK? YES NO BOTH
16. LIST ANY ALLERGIES, INCLUDING THOSE TO MEDICATIONS: _____
17. LIST ANY MEDICATIONS YOU ARE TAKING: _____

HEALTH HISTORY
(CHECK ALL THAT APPLY)

| | |
|-------------------|-----------------------|
| <u>PERSONALLY</u> | <u>FAMILY MEMBERS</u> |
| YES NO | YES NO |

18. DIABETES
19. GLAUCOMA
20. OTHER EYE DISEASES /
 SURGERIES / LASIK
21. HIGH BLOOD PRESSURE
22. HIGH CHOLESTEROL
23. THYROID CONDITION

THANK YOU. PLEASE RETURN TO THE RECEPTIONIST