Dr. Lora J. Smith & Dr. Mario J. Saracino

1. PATIENT INFORMATION (Please Print):

Mr. Mrs. Ms. Dr. _____ Date _____ DOB _____ Age _____

Address _____ City _____ State/ZIP _____

Phone (H) _____ (W) _____ ss# _____

Occupation _____ Who may we thank for referring you to our practice? _____

Email Address (for professional communication only) _____

2. PERSONAL/FAMILY OCULAR/MEDICAL HISTORY:

Date of last eye exam _____ Location and Dr where services were performed _____

Do you have or have you previously had any of the following eye conditions? If NONE, check here □.

_____Double Vision _____Dryness _____Redness _____Headaches _____Foreign Body Sensation

_____Flashes of Light _____Strain _____Itching _____Vision Loss _____Mucous/Watery Discharge

_____Floaters/Spots _____Burning _____Eye Injury/Surgery _____Other

If yes to any of the above, please explain when, where and how long _____

Have you or any relatives been diagnosed with any of the following:

	YOU	RELATIVE		YOU	RELATIVE		YOU	RELATIVE
Glaucoma	_____	_____	Diabetes	_____	_____	Hepatitis	_____	_____
Cataracts	_____	_____	High Blood Pressure	_____	_____	Tuberculosis	_____	_____
Retinal Detachment	_____	_____	Thyroid	_____	_____	Smoker	_____	_____
Macular Degeneration	_____	_____	HIV/AIDS	_____	_____	Recreational Drugs	_____	_____
Lazy Eye	_____	_____	Heart Attack/Trouble	_____	_____	Cancer	_____	_____

3. REVIEW OF SYSTEMS – Do you have any conditions which affect the following systems?

_____ Ears, Nose, Throat _____ Gastrointestinal _____ Skin Disorders _____ Endocrine

_____ Cardiovascular _____ Genitourinary _____ Neurological _____ Hematologic/Lymphatic

_____ Respiratory _____ Musculoskeletal _____ Psychiatric _____ Allergic/Immunologic

Medications and OTC/Vitamins:

_____

_____

Do you have any allergies? _____ Are you pregnant or nursing? _____

Family Physician _____ Address _____ Phone _____

4. PAST FAMILY and SOCIAL HISTORY:

Past History (please include any injuries, surgeries or hospitalizations) _____

Family History (please include any family diseases which may be hereditary) _____

Social History (please include any past and current activities, hobbies & sports) _____

5. CONTACT LENS HISTORY – please check here if you do not currently wear them □. Would you like to? _____

What type lenses do you wear? AcuVue/Bausch & Lomb/Ciba/ Cooper/Other. What solutions do you use?_____

Do you sleep in your contact lenses? Y N How long before you change/throw away your lenses? _____

Are they comfortable? Y N Is your vision optimal with them? Y N

6. **FINANCIAL POLICY**:

BY SIGNING HERE I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL FEES THAT MAY NOT BE COVERED BY MY BENEFITS OR INSURANCE. _____

**IF THE PATIENT IS A DEPENDANT, SIGNATURE OF PARENT/GUARDIAN _____

**THIS WAS REVIEWED BY PATIENT/PARENT/GUARDIAN: Date _____ Signature _____

**THIS WAS REVIEWED BY PATIENT/PARENT/GUARDIAN: Date _____ Signature _____

**THIS WAS REVIEWED BY PATIENT/PARENT/GUARDIAN: Date _____ Signature _____

**THIS WAS REVIEWED BY PATIENT/PARENT/GUARDIAN: Date _____ Signature _____