WELCOME BACK TO OUR OFFICE

Dr. Yvonne D. McBride, O.D.

PATIENT PERSONAL INFORMATION

Last: _____

First: _____ MI: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Patient's SSN: _____

Employer or School: _____

Occupation or Grade: _____

Spouse or Parent's Name: _____

Spouse or Parent's Work: _____

Date of Birth: _____ Age: _____ Sex: ❑ M ❑ F

Email Address: _____

What is the major purpose of this visit? _____

_____

Any problems with your present contact lenses or glasses? _____

_____

PATIENT MEDICAL HISTORY

Name of Family Physician: _____

City: _____ Last Physical Exam: _____

Current Medications - Rx or Over the Counter (List medications including eye drops,vitamins and birth control pills): _____

_____

_____

Allergies to Medications: ❑ Yes ❑ No If yes,what? _____

_____

Have you ever been diagnosed or treated for the following?

- ❑ Chronic Fever
- ❑ Recent Weight Loss/Gain
- ❑ Skin Dryness/Lumps
- ❑ Headaches
- ❑ Migraines
- ❑ Seizures
- ❑ Head Injury/Surgery
- ❑ Allergies/Hay Fever
- ❑ Sinus Congestion
- ❑ Post Nasal Drip
- ❑ Hearing Loss
- ❑ Chronic Cough
- ❑ Dry Throat/Mouth
- ❑ Freq.Urination
- ❑ Hot/Cold Frequently
- ❑ Thyroid Problems
- ❑ Other Glands
- ❑ Cholesterol
- ❑ Syphilis
- ❑ HIV
- ❑ Hepatitis
- ❑ Gonorrhea
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Vascular Disease
- ❑ Diarrhea
- ❑ Constipation
- ❑ Genital Problem
- ❑ Painful Urination
- ❑ Blood in Urine
- ❑ Rheumatoid Arthritis
- ❑ Muscle Pain
- ❑ Joint Pain
- ❑ Bleeding Problems
- ❑ Anemia
- ❑ Asthma
- ❑ Chronic Bronchitis
- ❑ Emphysema
- ❑ Depression
- ❑ Anxiety
- ❑ Other Psychiatric
- ❑ Cancer
- ❑ Lupus

OFFICE USE ONLY

ROS- PP(1) EXT (2-9) COMP(10) CH=PP_____ EPF_____

PFSH- PP(1) COMP(2-3) DET_____ COMP_____

PATIENT EYE HISTORY

Date of Last Eye Exam: _____ By Whom: _____

Have you ever been diagnosed or treated for the following?

- ❑ Cataracts
- ❑ Corneal Abrasion
- ❑ Eye Infection
- ❑ Eye Injury
- ❑ Glaucoma
- ❑ Iritis/Uveitis
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Other Eye Disorders

Do you experience or have you ever experienced?

- ❑ Blurry Vision
- ❑ Burning
- ❑ Tearing
- ❑ Headaches
- ❑ Double Vision
- ❑ Flash of Light
- ❑ Floaters/Spots
- ❑ Grittiness
- ❑ Itchiness
- ❑ Tired Eyes
- ❑ Sunlight Sensitivity
- ❑ Cross.Eyes/Eye Turn
- ❑ Diff.Seeing at Night
- ❑ Uncomfortable Glasses
- ❑ Occasional Dryness

Do you... (check box if your answer is yes)

- ❑ Work at a computer?
- ❑ Think you might benefit from thinner, lighter lenses?
- ❑ Have interest in a "Trial" of the latest contact lens design?
- ❑ Spend time outdoors? How much? _____ hrs./week
- ❑ Have prescription sunglasses?
- ❑ Prefer not to wear your glasses at times?
- ❑ Want information on Lasik Vision Correction surgery?
- ❑ Have more than one pair of current Rx glasses?
- ❑ Have children?
- ❑ Have family members in need of eye care?

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind? _____ Solutions used: _____

Are you satisfied with the vision and comfort? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Which would you prefer? ❑ clear contacts ❑ colored contacts (chg. eye color)

PATIENT SOCIAL HISTORY

Do you...(check box if your answer is yes)

- ❑ Smoke
- ❑ Take Illegal Drugs
- ❑ Drink Alcohol
- ❑ Drive
- ❑ Have visual driving difficulties

Are you pregnant or nursing? ❑ Yes ❑ No ❑ Not Applicable

FAMILY MEDICAL HISTORY

Is there a family medical history of any of the following? Who?

- ❑ Blindness _____
- ❑ Cataracts _____
- ❑ Corneal Prob. _____
- ❑ Glaucoma _____
- ❑ Lazy Eye _____
- ❑ Macular Degeneration _____
- ❑ Retinal Prob. _____
- ❑ Diabetes _____
- ❑ Heart Disease _____
- ❑ Lupus _____
- ❑ High Blood Press. _____
- ❑ Kidney Disease _____
- ❑ Thyroid Disease _____
- ❑ Cancer _____

Do you participate in a flex spending account? ❑ Yes ❑ No

How will you settle your account today?

❑ Cash ❑ Check ❑ Credit Card ❑ Other _____

Today's Date

Signature *(parent or guardian if patient is under 18 years old)*