MERIDIAN EYES

Welcome to our office! Thanks for coming today.

Name: _____ *Birth Date:* _____ Age: ____ *Gender:* *m* *f*

Address: _____ *Nickname:* _____

City, State, Zip:_____ *Cell phone:* _____Text OK? Y N

Employer/School: _____ *e-mail:* _____

Occupation: _____ *Referred by*: _____ *Name of Parent/Guardian/Spouse* _____

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REASON FOR VISIT: _____ Glasses ☐ Contact Lenses ☐

SYMPTOM LIST- *Please check those you have recently experienced (last 30 days)*

☐ Double vision	☐ Eye fatigue/blur viewing screens	☐ Excessive tearing
☐ Frequent headaches	☐ Eyestrain with sustained reading	☐ Burning eyes
☐ Intermittently blurred vision	☐ Increased light sensitivity	☐ Itching eyes

MEDICAL HISTORY - *Please check if you or any of your <u>immediate</u> related family members have had any of the following:*

	Self	Family		Self	Family		Self	Family
Allergies	___	___	Heart condition	___	___	Macular degeneration	___	___
Arthritis	___	___	High blood pressure	___	___	Retinal Detachment	___	___
Asthma	___	___	High cholesterol	___	___	Glaucoma	___	___
Diabetes	___	___	Thyroid disease	___	___	Lazy eye	___	___
Epilepsy	___	___	Head injury	___		Eye injury or surgery	___	

Other medical conditions _____

Eye injuries/surgeries and year occurred _____

> *Height*: ___ft ____in. *Weight:* _____lbs >(Women) Are you pregnant or nursing? Yes No

>Primary Care Physician: Name: _____Medical group: _____ Ph:_____

>List prescription and non-prescription medications used: (☐ NONE) *(If available, please provide medication list to receptionist.)*

_____

_____

>Drug Allergies/ Reaction: (☐ No known drug allergies) _____

>Hobbies/pastimes: _____ Hrs/day you use screens (including smart phone): ____

SOCIAL HISTORY

> Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker

>NEW PATIENTS ONLY: ***Preferred Language:*** ☐ English ☐ Spanish Other _____

Race : ☐ American Indian or Alaska Native ☐ Black or African American ***Ethnicity:*** ☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Not Hispanic or Latino

OFFICE USE ONLY: _____ **NEXT APPT**: OV CL ✓ ___ Optomap AF **WHEN**: 24 hr ASAP ~2 wks 3 mnths other:_____

NCT R) _____ L) _____ TIME_____ ☐ NCT rec Account #_____

Intake 2020-11-6 Doctor Notes: _____ Data Entry Complete _____