WELCOME BACK TO OUR OFFICE

Loock Perfect Image Eyecare

Patient Information

Patient's Name_____DOB_____ Age_____

Address_____

Email Address:_____

Home Phone #_____ Daytime/Cell # _____

Vision Insurance_____ Medical Insurance_____

Health History

Name of family physician_____ Date of last physical_____
List all medications you currently take_____
_____
List any allergies to medications_____
Have you had any changes in your health since your last examination? If yes, please explain
_____

Do you or does anyone in your family have a history of the following? (**Mark "S" for self and "F" for family**)

__Diabetes	__High Blood Pressure	__Heart Problems
__Cancer	__Thyroid Condition	__Glaucoma
__Cataracts	__Macular Degeneration	__Blindness
		__NONE

Do you have children? _____ Ages_____
Are you currently pregnant or nursing? _____
For patients 14 and older: (some insurance carriers require this information)
Do you smoke? _____ Do you drink alcohol? No_____
Yes, occasionally____
Yes, regularly_____

Ocular History

Reason for today's examination? _____
Have you had any injuries/surgeries to your eyes since your last examination with us? If yes, please explain_____

Do you wear glasses currently? _____ Contact lenses? _____
Are you interested in wearing contact lenses? _____
Are you interested in LASIK Refractive Surgery? _____
Do you have dry eyes? _____
Do you have seasonal allergies? _____

Signature of patient or parent/guardian (if under 18) _____

Date _____

*Please complete this form and bring it to your appointment. Thank you!