OPTOMETRY PATIENT INTAKE FORM

Thank you for taking the time to complete this form in its entirety.

PATIENT INFORMATION

Name	Johanna Kimbell	**Date of birth**	2021-02-01
Gender	Female	**Marital status**	Single
Address 1234 Main Street San Francisco Bay, Northwest Territories BNV098 Canada		**Email** lillahorvath@hotmail.com	
Phone (Home)	555-555-5555	**Phone (Work)**	555-555-5555
Phone (Cell)	555-555-5555	**Occupation**	Electrical Engineer

What is the reason for your visit?

- [X] Yearly checkup
- [ ] Eyestrain
- [X] Headaches
- [ ] Double-vision
- [ ] Burning
- [ ] Discharge
- [ ] Floaters
- [ ] Blurred vision
- [ ] Eye pain
- [ ] Poor night vision
- [ ] Total loss of vision
- [ ] Itching
- [ ] Infection
- [ ] Grittiness
- [ ] Dry eyes
- [ ] Sever sensitivity to light
- [ ] Bothersome night glare
- [ ] Redness
- [ ] Tearing
- [ ] Flashes of light
- [X] Other

Other reason for visit
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

How did you hear about us?

FAMILY DOCTOR

Name	Bernard Klein	**Phone**	555-555-5555

EMERGENCY CONTACT

Name	Jamie Farrthing	**Phone**	555-555-5555
Relationship	Father		

EYE-RELATED MEDICAL HISTORY

Do you or any family members have a history of the following eye problems?

- [X] Amblyopia (Lazy Eye)
- [ ] Difficulty Judging Depth
- [ ] Eye Injury
- [ ] Cataracts (Hazing of internal lens)
- [ ] Macular Degeneration
- [X] Retinitis Pigmentosa
- [ ] Regular Headaches
- [ ] Diabetic Retinopathy
- [ ] Itchy Eyes
- [ ] Keratoconus
- [ ] Color Blindness
- [ ] Ocular Melanoma
- [ ] Double Vision
- [ ] Eye Surgery
- [ ] Dry Eyes
- [ ] Glaucoma (Tunnel vision)
- [ ] Retinal Detachment
- [ ] Strabismus (Eye Turn)

☐ No reported eye problems ☒ Other

Other eye-related problems
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

When was your last eye exam?	2021/02/08

Do you have difficulty with any of the the following?

☒ Seeing up-close ☐ Seeing the computer ☐ Seeing far away ☒ Other

Other vision difficulties
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

Where did you get your last pair of glasses?	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed.

What do you value most in glasses?

☒ Technology ☐ UV Protection ☐ Appearance ☐ Ease of use
☐ Durability ☐ Cost ☒ Other

Other things you value most in glasses
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

CONTACT LENSES

Do you or have you ever worn contact lenses?	Yes
Do you ever sleep in your contact lenses?	Yes
Are you happy with your contact lenses?	Yes
How often do you wear contact lenses?	5-7 times per week
How often do you dispose of your contact lenses?	Daily
What brand of contact lenses do you wear?	csdvcvsfvbfbvvfa
Which contact lens cleaning solution do you use?	Other
Other lens cleaning solution	Lorem ipsum dolor sit amet, consectetur adipiscing

What do you value most in contact lenses?

☒ Comfort ☐ UV Protection ☐ Breathability ☐ Convenience
☐ Health ☐ Cost ☒ Other

Other things you value most in contact lenses
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

Which of the following services will you be needing?

☒ Annual Comprehensive Visit (Eye Health and Glasses Update) ☐ Contact Lens Update (Renewing CL Rx)
☐ New Contact Lens Fitting (Training and Evaluation) ☐ Dry Eye Consultation and Therapy
☐ Ortho K (Corneal Reshaping and Nearsighted Control) ☒ Corneal Prosthetic (Specialty fitting for corneal

degenerative disease)

- [ ] Refractive Surgery Consultation
- [ ] Eyewear Consultation (Appointment with Optician)
- [ ] Glaucoma Evaluation
- [x] Other

Other services needed
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

GENERAL MEDICAL HISTORY

Do you or any family members have a history of the following health problems?

- [ ] High Blood Pressure
- [ ] Allergies
- [ ] Asthma/COPD
- [x] Blood clots
- [ ] Depression
- [ ] Heart attack
- [ ] Kidney Disease
- [ ] Neurologic disorder
- [x] High Cholesterol
- [ ] Multiple Sclerosis
- [ ] Arthritis
- [ ] Bowel disease
- [ ] Diabetes Type 1
- [x] Stroke
- [ ] Kidney Stones
- [ ] No Reported health problems
- [ ] Thyroid Disease
- [ ] Anxiety
- [ ] Autoimmune disease
- [ ] Cancer
- [ ] Diabetes Type 2
- [ ] HIV-AIDS
- [ ] Liver disease
- [x] Other

Other general health problems
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

List current medications

Medication name	Dosage frequency	Reason for taking
Medication name	Dosage	Blood pressure

List current allergies

Allergy	Medication	Reaction
Hay fever	antihistamines	drwosiness

List past surgeries and dates

Body area	Type of surgery	Date
abdomen	gallbladder	2018

List lifestyle activities (ie. Intoxicants, Smoking, etc)

Activity	Frequency	Years
Smoking	1 pac/day	20

REVIEW OF SYSTEMS

Do you have any of the following symptoms today?

- [x] Neck Pain
- [ ] Fevers/Chills
- [ ] Dizzy/Lightheaded
- [ ] Nose bleeds
- [ ] Shortness of breath
- [ ] Heart Palpitation
- [ ] Headache
- [ ] Unexplained weight loss
- [ ] Ear ringing
- [ ] Blood in Sputum
- [ ] Angina/Chest Pain
- [ ] Leg pain with walking
- [ ] Facial pain/numbness
- [ ] Night Sweats
- [ ] Hoarseness
- [x] Persistent Coughing
- [ ] Ankle swelling
- [ ] Wake short of breath

☐ Abdominal pain	☐ Blood in stool	☐ Bloating
☒ Constipation	☐ Diarrhea	☐ Heartburn
☐ Nausea/Vomiting	☐ Blood in urine	☐ Heavy/Painful menses
☐ Swollen glands	☐ Blood Clots	☐ Bleeding easily
☐ Joint Pain / Swelling	☐ Breast lump	☐ Skin rash
☒ Depression	☐ Poor sleep	☐ No Symptoms
☒ Other		

Other symptoms
Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do eiusmod tempor incididunt ut labore et dolore magna aliqua.

INSURANCE

Do you have dental insurance?	Yes		
Insurance company name	SunLife Insurance Company		
Certificate / ID number	123456	**Group policy number**	41654654
Are you a dependant?	Yes	**Relationship to the insured**	Son
Name of insured	Conrad Black	**Insured date of birth**	2021-02-23

AUTHORIZATION

Consent

✔ I give consent to the release of relevant findings to other health care providers, the use of my email for methods of communication to and from this office, and this office for direct billing to my insurance, on my behalf, when available.

Signature