



WELCOME TO RAMSEY EYE CLINIC

Name _____ Today's Date _____

Mailing Address _____

City, State, Zip _____

Date of Birth _____ Age _____ Sex: M F

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # (Insurance Info Only) _____

How did you hear about our office? (please circle)

Direct Mail Newspaper Internet Community Event

Insurance Friend/Relative (who?) _____

Drive by Phone Book: (Which one?) _____

Email address (used for recall reminders and special events) _____

Medical History

Do you have any allergies to medications? Yes No Which _____

Are you pregnant and/or nursing? Yes No

List any medications you are taking (oral contraceptives, aspirin, over the counter medications and home remedies)

Last Physical? Name of Primary Care Physician: _____

Visual Needs

Do you wear glasses? Yes No If yes, how old are your current lenses? _____

Do you wear contact lenses? Yes No If yes, how old are your current lenses? _____

Type of contacts: soft rigid extended wear Are they comfortable? Yes No

Are you planning to get new glasses today? Yes No Only if Rx changes

Are you planning to get new contacts today? Yes No Only if Rx changes

Date of last eye exam _____

Do you.....

Work at a computer for long periods of time? Yes No

Have only one pair of glasses? Yes No

Want information on thinner/lighter lenses? Yes No

Spend a lot of times outdoors? Yes No

Ever find a need for prescription sunglasses? Yes No

Have problems with glare or reflections? Yes No

Does your work require safety glasses? Yes No

Participate in sport activities? Yes No

Want information about ordering contacts on-line? Yes No

Want information about corrective vision surgery? Yes No

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. This information is important for medical purposes as well as compliance with insurance directives.

Yes I would prefer to discuss my Social History information with my doctor.

Do you use tobacco products? Yes No

Do you drink alcohol? Yes No

Have you ever been exposed to or infected with: (please circle)

Gonorrhea Hepatitis HIV Syphilis

PLEASE COMPLETE INFORMATION ON NEXT PAGE