WELCOME BACK TO OUR OFFICE

Today's Date ______________________

Patient Information

Last ______________________

First ______________________ MI __________

Street ______________________

City ______________________ State __________

Zip Code ______________________

Home Phone ______________________

Work 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

E-mail Address ______________________

What is the major purpose of this visit? ______________________

____

Any problems with your current contact lenses or glasses?

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The mission of Dr. Malcolm Kelly and the staff of Oxford Family Eyecare is to contribute to a lifetime of healthy vision. Our objective is to provide quality care and personal attention that will result in complete patient satisfaction.

Our staff is committed to continuing education in order to remain at the forefront of our profession and will always offer the latest eye care technology, professional services, and products.

The visual needs and wellness of each and every patient will always be our first priority.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation

Vision Insurance ______________________

Subscriber Name ______________________

Subscriber SSN ______________________

Subscriber Birth Date ______________________

Primary Medical Insurance ______________________

Subscriber Name ______________________

Subscriber SSN ______________________

Subscriber Birth Date ______________________

Do you participate in a flex spending account?

❏ Yes ❏ No

How will you settle your account today?

❏ Cash ❏ Check ❏ Credit Card

Lifestyle Questions

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

❏..work at a computer?

❏..think you might benefit from thiner, lighter lenses?

❏..have interest in a "test drive" of the latest contact lens designs?

❏..spend time outdoors? How much? ____Hrs/week

❏..have prescription sunwear?

❏..prefer not to wear your glasses at times?

❏..want information on Laser Vision Correction surgery?

❏..have interest in a non-surgical approach to vision correction?

❏..have more than 1 pair of current Rx eyewear?

❏..have children?

❏..have family members in need of eyecare?

❏ Blurry Vision
❏ Cataracts
❏ Crossed eye/Eye turn
❏ Dry Eyes
❏ Eye Infections
❏ Flash of light
❏ Glaucoma
❏ Headaches
❏ Itchiness
❏ Macular Degeneration
❏ Migraine Headaches
❏ Retinal Detachment
❏ Tearing
❏ Uncomfortable Glasses
❏ Other eye disorders
❏ Burning
❏ Corneal Abrasions
❏ Double Vision
❏ Eye Injury
❏ Floaters/Spots
❏ Grittiness
❏ Iritis/Uveitis
❏ Lazy Eye
❏ Occasional dryness
❏ Sunlight Sensitivity
❏ Trouble seeing at night
❏ Other ______________________

____

Patient Medical History

Name of Family Physician ______________________

Town ______________________

Date of Last Physical Check-up ______________________

CURRENT MEDICATIONS (Rx or over the counter)
(List name of medications including eye drops, vitamins & birth control pills)
____

____

~~Allergies to medications? ❑ Yes ❑ No~~

If so, what medications? ______________________

____

Have you had any surgeries? ❑ Yes ❑ No

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Aids/HIV	❑	❑
Allergies	❑	❑
Arthritis	❑	❑
Blood/lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Lupus	❑	❑
MS	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Throat Infections	❑	❑
Parkinson's Disease	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑
Other	❑	❑

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Patient Eye History

Date of Last Eye Exam ______________________

By Whom? ______________________

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind? ______________________

Solutions used ______________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses?
❑ Clear ❑ Colored

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

Family Medical History (Check all that apply)

Is there a family medical history of any of the following?
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother, Father, Sister, Brother, Self)
Blindness	❑ ______________ Note Relationship
Cataracts	❑ ______________
Corneal Problems	❑ ______________
Diabetes	❑ ______________
Glaucoma	❑ ______________
Heart Disease	❑ ______________
Lazy Eye	❑ ______________
Macular Degeneration	❑ ______________
Retinal Problems	❑ ______________
Other	❑ ______________