



WELCOME 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?

Very Important! New Patients Only:

Who may we thank for referring you to our office?
 Name of friend or relative? _____

If not referred, how did you choose our office?

- Another Dr.
- Insurance List
- Saw Sign/Building
- Newspaper/Radio/TV
- Yellow Pages: Which directory? _____
- Web Page: Which Web Site? _____
- Other _____

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 thinner, 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?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Flash of light | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Occasional dryness |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Sunlight Sensitivity |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tearing | _____ |
| <input type="checkbox"/> Uncomfortable Glasses | |
| <input type="checkbox"/> Other eye disorders | |

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	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/lymph	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
MS	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/> _____ <small>Note Relationship</small>
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Other	<input type="checkbox"/> _____

