

Patient Name (Print): \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Occupation: \_\_\_\_\_ Gender: M / F

**Due to current Federal Medical Guidelines, we are required to obtain the following information**

**Preferred Language:** English / Spanish      **Preferred Communication Preference:** Email / Postal Mail / Telephone  
**Race:** Black/African American, American Indian/Alaska Native, Hispanic, Asian, White, Native Hawaiian/Other Pacific Islander  
**Ethnicity:** Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Not Hispanic or Latino

**What is the main reason for your visit today?** \_\_\_\_\_ **Do you wear?** Contacts / Eyeglasses **Are you interested in contacts?** Y / N

**Medical/Family History**

Please list current medications: \_\_\_\_\_

List any allergic reactions to **medications or eye drops:** \_\_\_\_\_

Women – Are you pregnant? Y / N

**Please indicate if any of the conditions apply:**

Disease/Condition	Yourself			Family Member		Relationship (Blood Relatives Only)
	Yes	No		Yes	No	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>				
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>				
Other:	_____					

Are you diabetic? Y/N If so, what year were you diagnosed? \_\_\_\_\_ What was your blood sugar today? \_\_\_\_\_  
 What is your most current HbA1C? \_\_\_\_\_

**Review of Systems**

Please indicate below (circle) if you have any of the following conditions:

**Social** Tobacco Use: Current Smoker / Former Smoker / Non-Smoker Non-prescription drugs Alcohol Consumption

**Allergic/Immunologic**

Lupus (SLE)  
 Rheumatoid Arthritis  
 Environmental Allergies  
 Seasonal Allergies  
 Other (i.e., Latex)

**Ear, Nose and Throat**

Sinusitis  
 Upper Respiratory Tract Infection  
 Other

**Gastrointestinal**

Crohn's Disease  
 Colitis  
 Acid Reflux/Ulcer  
 Other

**Skin/Integumentary**

Eczema  
 Rosacea  
 Psoriasis  
 Other

**Psychiatric**

Depression  
 Bi-Polar  
 Schizophrenia  
 Other

**Cardiovascular**

High Blood Pressure  
 Heart Disease  
 Stroke  
 Vascular Disease  
 High Blood Cholesterol

**Endocrine/Glands**

Diabetes  
 Hormone Dysfunction  
 Thyroid Dysfunction  
 Other

**Respiratory**

Asthma  
 Bronchitis  
 Emphysema  
 Other

**Muscle/Skeletal**

Arthritis  
 Fibromyalgia  
 Ankylosing Spondylitis  
 Other

**Genital/Urinary**

Urinary Tract Infection  
 HIV Positive  
 Herpes/Chlamydia  
 Other

**Hematologic/Lymphatic**

Anemia  
 Leukemia  
 Bleeding Disorder  
 Other

**Neurological**

Multiple Sclerosis  
 Epilepsy  
 Tremors  
 Other

**General Health**

Weight loss/gain  
 Fever  
 Fatigue  
 Trauma

**Insurance Information:** Are you covered by vision coverage? Y/N If yes, please list: \_\_\_\_\_

SSN/Insurance #: \_\_\_\_\_ Do you have secondary vision coverage? \_\_\_\_\_

At Eye Boutique we will make every effort to check your eligibility with your insurance carrier. Because of the ever-changing information with insurance companies and/or circumstances beyond our control, WE CANNOT GUARANTEE THAT YOUR VISION BENEFITS WILL ALWAYS COVER PART OR ALL OF YOUR PURCHASES FROM US. You will be responsible for any unpaid balance. If you have any concerns regarding your insurance benefits and eligibility, we urge you to contact your insurance carrier before you order products or services from us.

**Lifestyle Information:** To help us assist you with your eye care needs, please circle all that apply:

Boating/Fishing Computer use (give % of time each day \_\_\_\_\_) Shooting Golfing Motorcycling Bicycling  
 Participate in Sports Swimming Driving Hunting Close-up work Woodworking Use of Power Tools  
 Intermediate Work Gardening Reading Hiking Other: \_\_\_\_\_

**Please sign to acknowledge this form is current and that you received a copy of Eye Boutique, Inc.'s Notice of Privacy Practices.**

Patient's Signature or legal guardian : \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by Doctor's initials: \_\_\_\_\_

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**FOR OFFICE USE:**

**Eyeglasses 1: Date :** \_\_\_\_\_

OD \_\_\_\_\_ Add: \_\_\_\_\_ Type: \_\_\_\_\_

OS \_\_\_\_\_ Add: \_\_\_\_\_ Material: \_\_\_\_\_  
Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

**Eyeglasses 2: Date:** \_\_\_\_\_

OD \_\_\_\_\_ Add: \_\_\_\_\_ Type: \_\_\_\_\_

OS \_\_\_\_\_ Add: \_\_\_\_\_ Material: \_\_\_\_\_  
Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

**Contact Lenses:**

Brand: \_\_\_\_\_ OD \_\_\_\_\_

BC: \_\_\_\_\_ OS \_\_\_\_\_

**New Contact lens or trials**

Brand: \_\_\_\_\_ OD \_\_\_\_\_

BC: \_\_\_\_\_ OS \_\_\_\_\_

**Based on the patient's lifestyle, prescription and ocular health needs, what products do you recommend?** (completed by Optometrist)

Teflon Coating / Prescription Sunglasses / Back-up pair of eyeglasses for contact lens wearers / Progressive No-Lines

Polarized / UV protection / Multiple Pair

Additional Notes:

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