WELCOME TO DR. WRIGHT'S OFFICE

Today's Date: _____ _____ _____ _____ _____ _____

Patient Name:_____ M F Birth date:_____ Age:_____ Single_____ Married_____

Address: _____City_____ Zip_____ Home #:_____ Cell Phone #_____

Employer:_____ Occupation: _____Work #_____

Height_____ Weight_____ Driver Lic#_____ SS#_____

Name of Medical Doctor:_____ Last Medical Exam_____ Last Eye Exam_____

Who referred you to our office?_____ **E-Mail**:_____ Fulltime Student?_____

Insurance Information

Name of Insured:_____ Insurance Co. Name_____

SS# of Insured: _____Birth date of Insured:_____ Relationship to Patient:_____

Medical & Family Health History

Are you allergic to any medication? Yes No If yes, please explain:_____

List any medications you are currently taking including aspirin, or over the counter medications:_____

_____

Have you ever had an eye infection / injury / surgery?_____

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

Do you wear contact lenses? Yes / No If yes, how old are you present lenses? _____

Are you pregnant and/ or nursing Yes / No

Please indicate if you or any family member (living or deceased) have had any of the following conditions:

Blindness: Yes / No_____ Cataracts: Yes / No_____

Crossed Eyes: Yes / No_____ Glaucoma: Yes / No_____

Macular Degeneration: Yes / No _____ Retinal Detachment: Yes / No_____

Arthritis: Yes / No_____ Cancer: Yes / No_____

Diabetes: Yes / No_____ Heart Disease: Yes / No_____

High Blood Pressure: Yes / No _____ Kidney Disease: Yes / No_____

Autoimmune Disease: Yes / No_____ Thyroid Disease Yes / No_____

Lazy Eye: Yes / No_____ Other: Yes / No_____

SOCIAL HISTORY

This information is kept strictly confidential, however you may discuss this portion with the doctor if you prefer.
Do you drive? Yes / No If yes, do you have visual difficulty when driving? Yes / No If yes, please describe:

Do you use any tobacco products? Daily_____ Weekly_____ Occasionally_____ Never_____
Do you drink alcohol? Daily _____ Weekly _____ Occasionally_____ Never _____
Do you use illegal drugs? Daily _____ Weekly _____ Occasionally _____ Never_____
Have you ever been exposed to or infected with: Gonorrhea_____Hepatitis_____HIV_____Syphilis_____

REVIEW OF SYSTEMS

Please **circle**, if you have any chronic problems in the following areas:

CONSITUTIONAL
Fever/Weight Loss/Gain
CARDIOVASCULAR
Dizziness/Irregular Heartbeat
Pacemaker/Palpitations
EARS/NOSE/MOUTH/THROAT
Sinus Congestion
Dry Throat/Mouth
Chronic Cough/Sore Throat
Vertigo
Ear Pain
EYES
Loss of Vision/Blurred Vision
Distorted Vision/Halos
Dryness/Redness
Mucous Discharge
Sandy/Gritty Feeling
Itching/Burning
Foreign Body Sensation
Excess Tearing/Watering
Glare/Light Sensitivity
Eye Pain/Soreness
Chronic Infection of Eye or Eye Lid
Sties/Chalazion
Flashes/Floaters in Vision
Tired Eyes
RESPIRATORY
Coughing/Wheezing
Asthma
Chronic Bronchitis
Emphysema

GASTROINTESTINAL
Genitals/Kidney/Bladder/Constipation
Frequent Urination/Incontinence/Diarrhea
MUSCULOSKELETAL
Rheumatoid Arthritis
Muscle Pain/ Cramps
SKIN PROBLEMS Yes/No
NEUROLOGICAL
Headaches/Migraines
Seizures
PSYCHIATRIC
Depression/Anxiety
Unable to Sleep
ENDOCRINE
Thyroid/Other Glands
Excessive Thirst/
LYMPHATIC/HEMATOLOGCA
Anemia
Excess Bleeding
ALLERGIC/IMMUNOLOGIC
Animal/Bee Sting
Runny Nose
Excessive Sneezing
Food Allergy
Seasonal

If you **CIRCLED** any of the above or have a condition not listed, please explain:_____

_____

I HEREBY GIVE AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE TO DR. CHRISTOPHER WRIGHT O.D., FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE. I HEREBY AUTHROIZE THIS HEALTHCARE PROVIDER TO RELEASE ALL INFORMATION NECESSARY TO SECURE ALL PAYMENT OF BENEFITS.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

THANK YOU FOR HELPING US TO KNOW YOU BETTER