



## Welcome To Our Office!

7511 S. McClintock Drive, Tempe, AZ 85283  
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www.tempeeyecareassociates.com

Please fill out the information below completely.  
This information is kept strictly confidential.

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex M \_\_\_\_ F \_\_\_\_ SS# \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
May we contact you by email? Y / N If yes, provide address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
If you are a student: Where? \_\_\_\_\_ What level? \_\_\_\_\_  
Responsible Party (if different from above): Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_  
Were you referred to us? If so, by whom? \_\_\_\_\_

### PERSONAL EYE INFORMATION

Last complete eye exam? \_\_\_\_\_ Where? \_\_\_\_\_ Dilated? Y N  
Reason for today's visit? \_\_\_\_\_  
Have you ever had an eye injury or surgery? If yes, type and date \_\_\_\_\_  
Do you wear glasses? Y / N Since? \_\_\_\_\_ For Far Vision? Near Vision? Both?  
Do you wear contact lenses? Y / N Since? \_\_\_\_\_ Type \_\_\_\_\_  
Have you ever been diagnosed with cataracts? Y / N Glaucoma? Y / N Retinal Detachment? Y / N Lazy eye? Y / N  
Floaters? Y / N Macular Degeneration? Y / N Other diagnosis? \_\_\_\_\_  
Do you ever experience (circle): Blurring Double Vision Dryness Tearing Headaches Sties Haloes  
Eye Pain Redness Vision Loss Burning Light Sensitivity Reduced Night Vision Flashes/Floaters  
Other \_\_\_\_\_  
Do you drive? Y / N Any visual difficulty when driving? Y / N If yes, explain: \_\_\_\_\_  
Do you use a computer? Y / N For work? Y / N How many hours/day? \_\_\_\_\_  
For leisure? Y / N How many hours/day? \_\_\_\_\_  
Any visual difficulty with computer use? Y / N explain \_\_\_\_\_  
Any hobbies with vision difficulties or special needs? Y / N If yes, please explain: \_\_\_\_\_

### FAMILY HISTORY

Please indicate any positive family history (along with relationship):  
Cancer/Tumors \_\_\_\_\_ Cataracts \_\_\_\_\_ Diabetes \_\_\_\_\_ Glaucoma \_\_\_\_\_ Headaches \_\_\_\_\_  
Heart Disease \_\_\_\_\_ High BP \_\_\_\_\_ Lazy Eye \_\_\_\_\_ MS \_\_\_\_\_ Retinal Detachment \_\_\_\_\_  
Thyroid Disease \_\_\_\_\_ Arthritis \_\_\_\_\_ Blindness \_\_\_\_\_  
Macular Degeneration \_\_\_\_\_ Other \_\_\_\_\_

**Please complete the medical information and sign on side two.**

Would you like the doctor to discuss a specific topic concerning vision care?

**Spectacles:** UV radiation; computer use; sports; no-line bifocals

**Contact lenses:** bifocals; daily wear; extended wear; disposables

**Ocular health:** dry eye treatment options; ocular surgery

**Other:** refractive therapy options

## PERSONAL MEDICAL INFORMATION

Last complete physical examination? \_\_\_\_\_ Primary care physician? \_\_\_\_\_

Have you ever had an adverse drug reaction? Y / N To what? \_\_\_\_\_

List current medications (Rx & OTC): \_\_\_\_\_

Are you pregnant? Y / N If yes, \_\_\_\_\_ wks/mos? Are you nursing? Y / N

Do you currently, or have you ever had any problems in the following areas?

Headaches	Y	N	Migraines	Y	N	Seizures	Y	N
Chronic cough	Y	N	Dry mouth	Y	N	Sinus congestion	Y	N
Asthma	Y	N	Bronchitis	Y	N	Emphysema	Y	N
Heart Disease	Y	N	Vascular disease	Y	N	High Blood Pressure	Y	N
Muscle pain	Y	N	Joint pain	Y	N	Rheumatoid Arthritis	Y	N
Anemia	Y	N	Fever	Y	N	Thyroid Disease	Y	N
Skin	Y	N	Stroke	Y	N	Hay Fever	Y	N
Diarrhea	Y	N	Constipation	Y	N	Kidney Disease	Y	N
Immunologic	Y	N	Psychiatric	Y	N	Bladder/Genitals	Y	N
HIV	Y	N	Hepatitis	Y	N	STD	Y	N
Hormonal	Y	N	M.S.	Y	N	Cancer/Tumors	Y	N

If you answered YES to any of the above, please explain: \_\_\_\_\_

Any condition not listed? \_\_\_\_\_

Have you been diagnosed with Diabetes? Y / N If yes, type and date of diagnosis? \_\_\_\_\_

Do you suffer from allergies? If yes, to what? \_\_\_\_\_

Other health problems: \_\_\_\_\_

List all major surgeries and (approx) dates: \_\_\_\_\_

Do you use cigarettes/tobacco products? Y / N Alcohol? Y / N Other substances? Y / N

If yes, please explain: \_\_\_\_\_

## INSURANCE INFORMATION

Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ of Primary Insured (if different from patient)

Do you have vision-care benefits? Y / N If yes, what type? \_\_\_\_\_

Medical (health) carrier? \_\_\_\_\_

**CONTACT LENS WEARERS WITH INSURANCE:** Contact lens patients are responsible for the difference in fees between eye examination fees (paid by your insurance coverage) and our normal/customary contact lens examination fees.

**Signature:** \_\_\_\_\_ **Date** \_\_\_/\_\_\_/\_\_\_

Doctor's review \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_