Pendleton Family Optometry
765-778-7524
Patient Information

Today's Date:_____

Last Name:_____ **First Name:**_____ **MI**_____ ☐ Male ☐ Female

Title:_____ **Suffix:**_____ **Date of Birth:**_____ **Height:**_____ **Weight:**_____

Nickname:_____ **Social Security Number:** _____

Address Line 1: _____ **Marital Status:**_____

Address Line 2:_____ **Employment Status:** Full Time, Part Time, Retired, Not employed

City:_____ **Employer:**_____

State:_____ **Zip:**_____ **Occupation:**_____

Home Phone:_____ **Preferred Language:**_____

Daytime Phone:_____ **Race:** ☐American Indian/Alaskan Native ☐Asian ☐Hispanic

Cell Phone:_____ ☐Black/ African American ☐Multi-racial ☐White

E-mail Address:_____ ☐Native Hawaiian/Islander

Is it okay to contact you by e-mail: Y / N **Ethnicity:** ☐Hispanic ☐Not Hispanic ☐Hawaiian/Islander

How would you like to be contacted? **Referred by:**_____

☐Cell Phone ☐E-mail ☐Home Phone ☐Work Phone

Primary Care Physician Name/ Phone:_____

Date of Last Eye Exam:_____ **Eyes Dilated:** Y / N

Have you had any of the following:

☐Crossed eyes ☐Lazy eye ☐Drooping eyelid ☐Eye infection ☐Eye injury

☐Eye surgery ☐Glaucoma ☐Cataracts ☐Macular degeneration

Your Eye Symptoms – Do you (patient) experience any of the following?

Blurred Vision	N	Y	Flashing Lights	N	Y	Seeing Rings Around Lights	N	Y
Distorted Vision	N	Y	Painful Eyes	N	Y	Color Vision Difficulties	N	Y
Double Vision	N	Y	Gritty/Sandy Eyes	N	Y	Depth Perception Problems	N	Y
Red Eyes	N	Y	Aching Eyes	N	Y	Losing Place While Reading	N	Y
Watery Eyes	N	Y	Drawing/ Pulling	N	Y	Night Vision Problems	N	Y
Itchy Eyes	N	Y	Dizziness	N	Y	Extreme Light Sensitivity	N	Y
Burning Eyes	N	Y	Excessive Squinting	N	Y	Discharge From Eyes	N	Y
Dry Eyes	N	Y	Other_____			Floating spots	N	Y

Personal Health History/Medical Conditions_____

_____

Family History- Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y	Glaucoma	N	Y	Heart Disease	N	Y
Cornea Disease	N	Y	Lazy Eye	N	Y	Diabetes	N	Y
Crossed Eyes	N	Y	High Blood Pressure	N	Y	Macular Degeneration	N	Y
Retina Disease	N	Y	Cancer	N	Y	Other_____		

Do you wear: ☐Glasses ☐Contact lenses

Type of contact lenses: ☐Rigid ☐Soft ☐Extended Wear ☐Other Are they comfortable? ☐No ☐Yes

How often do you replace your contact lenses? ☐Daily ☐1-2 Weeks ☐Monthly ☐Quarterly ☐Yearly ☐Other_____

Please provide any additional information you would like to add:_____

The information provided is true and complete to the best of my knowledge.

_____ _____

Patient Signature (or Guardian if patient is a minor) **Date**

_____ _____

Name of Person Completing Form (if not patient) **Relationship to Patient**