Welcome to our Office
Brazos Eye Center

PLEASE PRINT (write as legible as possible and **fill out every blank**)

Name: ______________________ Date of Birth: __________ Age: ________ Date: ________

Address: ______________________ City: ________ Zip Code: ______ Phone Number: __________

E-mail Address: __________________ Occupation: ______________ Employer: ______________

LAST Eye Exam: __________ Doctor: __________ LAST Medical Exam: __________ Doctor: __________

Who can we thank for referring you to our office today? ______________________________

INSURANCE: (Please supply both your Vision and Medical/Health Insurance below for our records)

Vision Insurance Name & ID: ______________________________

Medical/Health Insurance Name & ID: ______________________________

Primary Insured : ______________________ SS# _____ - _____ - _____ DOB: ____ / ____ /_____

REASON(S) FOR TODAY'S VISIT: (*MAIN* reason(s) why you are getting your eyes checked today)

PAST OCULAR HISTORY: (Please check if you ever had any of the following)

___ Eye Infection ___ Eye Injury ___ Lazy Eye ___ Cataract ___ Glaucoma ___ Macular Degeneration
___ Eye Surgery ___ Other: ______________________________

PAST MEDICAL HISTORY: (Please check if you have or ever had any of the following)

___ Hypertension ___ Respiratory Problem ___ Thyroid Problem ___ GI problem ___ Bone/Joint Problem
___ Diabetes ___ Other: ______________________________

If diabetic, are you type 1 or type 2: ______ What year were you diagnosed: ______ What is your Hemoglobin A1c: ______

List all major injuries, surgeries, or hospitalizations: ______________________________

____

Are you taking any medications? □ No. □ Yes. Please list: ______________________________

____

Are you allergic to anything (including medications)? □ No. □ Yes. Please list: ______________________________

____

Are you pregnant and/or nursing? □ No. □ Yes. How many weeks pregnant: ______________________________

Do you use tobacco products? □ No. □ Yes. Type/Amount/How long: ______________________________
Do you drink alcohol? □ No. □ Yes. Type/Amount/How often: ______________________________
Do you use recreational drugs? □ No. □ Yes. Type/Amount/How often: ______________________________

FAMILY HISTORY: (Please note any family history including parents, grandparents, siblings, children; living or deceased)

CONDITION	NO	YES	RELATIONSHIP	CONDITION	NO	YES	RELATIONSHIP
Blindness	□	□	____________	Diabetes	□	□	____________
Glaucoma	□	□	____________	High Blood Pressure	□	□	____________
Macular Degeneration	□	□	____________	Heart Disease	□	□	____________
Retinal Detachment	□	□	____________	Cancer (type?)	□	□	____________
Retinal Disease	□	□	____________	Other: ____________			____________

Do you currently wear glasses? □ No. □ Yes. How old are your current glasses: __________
Do you currently wear contacts? □ No. □ Yes.
Type of contacts: □ Soft □ Hard
If you are not currently wearing contact lenses, are you interested in contacts? □ No. □ Yes. □ Not Sure.