

Welcome To Capitol Optometry – Patient Information (Confidential)

Important: This form must be reviewed at each appointment. Please answer all questions.

Name _____ DOB _____ Age _____
Address _____ City _____ State _____ Zip _____
Phone(H) _____ Phone(W) _____ Phone(C) _____
E-mail _____
Last 4# of SSN _____ Occupation _____ Employer _____
Emergency Contact _____ Phone _____
Male/Female Single/Married/Divorced/Child/Partner Hobbies _____
Whom may we thank for referring you? _____

Medical Information

How is your general health? _____ Do you have problems with any of the following?
Gastrointestinal Y / N Cardiovascular Y / N Blood/lymph Y / N Skin Y / N
Ears/Nose/Throat Y / N Respiratory Y / N Urinary Y / N HIV/AIDS Y / N
Endocrine/Thyroid Y / N Muscles/bones Y / N Headaches Y / N Other _____
High blood pressure Y / N Allergies Y / N Cancer Y / N
Nervous System Y / N Mental Y / N Cholesterol Y / N

Please explain _____
Diabetes Yes/No Type _____ Date of diagnosis _____
Allergy to medication? Yes/No Which? _____ Reaction _____
Current medications _____ What for? _____
Have you had any operations? Yes/No Type? _____ When? _____
Name of family doctor _____ Date of last visit _____
Medical Insurance _____

Family History

High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Who _____	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Who _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Who _____	Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	Who _____
Strabismus/eye turn	<input type="checkbox"/>	<input type="checkbox"/>	Who _____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Who _____
Amblyopia/lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	Who _____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Who _____

Eye Use

Hours spent per day: on PC _____ on smart phone/PDA _____ on TV _____ Driving _____ Reading _____
Work computer is a: desktop/laptop Home computer is a: desktop/laptop
Symptoms after prolonged use? Headache Eye Strain Blurred Near Vision Burning/Itching
Dry Eyes Double Vision Blurred Distant Vision Light Sensitivity

Personal Eye Information

Date of last eye exam _____ Were you dilated? Yes/No
Do you have any eye conditions or problems? Yes/No Explain _____
Have you had any eye operations? Yes/No Explain _____ Date _____
Have you had any eye injury/infection? Yes/No Explain _____ Date _____
Please circle if you have the following:
Glaucoma Macular degeneration Retinal detachment
Cataracts Dry eyes Blurred vision
Do you wear glasses? _____ Contact lens? _____ Type/Brand _____
Additional information _____

I acknowledge that I have reviewed the Notice of Privacy Practices and Patient Rights and Office Policies of Capitol Optometry, and a copy of the notice is available upon request.
Signature _____ Date _____

Reviewed by _____ No changes Date _____
Reviewed by _____ No changes Date _____