Dr. Meryl Brownstein, O.D.

Today's Date: ___/____/____ Whom may we thank for referring you: __________________

Patient's Name: ______________________ Date of Birth: ____/_____/____ Age: ______

Mailing Address: ____
(Street) (Apt/ Fl.) (City) (State) (Zip Code)

Home Ph#: _________________ Cell Ph#: _________________

Occupation: ________________ Employer: _________________ E-mail: ______________

If a student: Grade: ______ School Name: _______________ Parent's Name: _________

INSURANCE INFORMATION:
Do you have a vision plan: ___Yes or ___No? Name of Vision Insurance:______________

Name of Medical Insurance: ___________________ ID Number: ____________________

Name of Primary Insured: ___________DOB:__/__/___Last 4-digits of Social Security ____

WILL TODAY'S EXAMINATION BE PAID FOR BY: (Circle One)

CASH CHECK CREDIT INSURANCE

Family Physician_____________________ Last general physical exam date: ___/__/____

Previous eye doctor's name: _________________ Last eye examination date: __/__/____
Are you being treated for any medical conditions now? ________Yes _______No
If so, what:
____
Are you pregnant? ____________ Yes ________ No
Do you consider your health? ________ Good ___________ Fair ___________ Poor
Do you take medications? __________ Yes __________ No
If so, list here:
____
Are you allergic to any medications? _______ Yes ___________ No

If so, list here: ____
Do you smoke? _________ Yes ___________No
Do you drink alcoholic beverages? ___________ Yes _________ No
Have you ever had a serious eye disease, eye injury? _______ Yes ___________ No

If so, explain: ____

Do you wear eyeglasses? ____________ Yes or __________ No
Do you wear contact lenses? ____________ Yes or __________ No
If yes, which type? _____________ Hard or ___________ Soft

Family History

_____ Allergies
_____ Asthma
_____ Cancer
_____ Diabetes
_____ Glaucoma
_____Drug Sensitivity
_____ Blindness
_____Hay Fever
_____ Skin Condition
_____ Hypertension
_____Tuberculosis
_____Thyroid Conditions
_____Cataracts
_____Poor Color Vision
_____Dry Eyes
_____Lazy Eye
_____Turned Eye
_____Migraine/Headache

Patient History

_____Allergies
_____Asthma
_____Blackouts
_____Cancer
_____Hypertension
_____Diabetes
_____Migraine/Headaches
_____Hay Fever
_____Heart Conditions
_____Skin Conditions
_____Thyroid Conditions
_____Tuberculosis

Patient Visual History

_____Blurry Vision
_____Eye Discomfort
_____Eyelids Twitching
_____Turned Eye
_____Light Sensitivity
_____Double Vision

_____Lazy Eye

_____Glaucoma

_____Loss of Vision
_____Watering Eyes
_____Itching Eyes
_____Burning Eyes
_____Red Eyes
_____Dry Eyes
_____Flashing Lights
_____Floaters or Spots
_____Headaches
Poor Color Vision