Connecticut Post Mall
1201 Boston Post Rd
Suite 2063
Milford, CT 06460
203.530.3000

## PLEASE COMPLETE ALL INFORMATION IN THIS BOXED AREA

☐ Mr. ☐ Ms. **NAME** (Last, First, MI)
☐ Mrs. ☐ Dr.

**ADDRESS** **CITY** **STATE** **ZIP**

**PRIMARY PHONE** ☐ Home ☐ Mobile **SECONDARY PHONE** ☐ Work ☐ Mobile **E-MAIL ADDRESS**

**DATE OF BIRTH** **AGE** **EMPLOYER** **OCCUPATION**

**REVIEW OF SYSTEMS:** Do you have any problems in these areas?
*Please circle or describe any checked 'yes' in the space below:*

- ☐ General / Constitutional — ex: fever, weight loss/gain
- ☐ Ears / Nose / Throat — ex: congestion, cough, dry mouth
- ☐ Cardiovascular — ex: high blood pressure, heart disease
- ☐ Respiratory — ex: asthma, emphysema, COPD
- ☐ Gastrointestinal — ex: diarrhea/constipation, IBS, Crohn's
- ☐ Genital/Kidney/Bladder — ex: frequent/painful urination, kidney dz
- ☐ Muscles, Bones, Joints — ex: arthritis, muscle/joint pain
- ☐ Skin — ex: rosacea, eczema, psoriasis
- ☐ Neurological — ex: headache, migrane, seizures
- ☐ Psychiatric — ex: anxiety, depression
- ☐ Endocrine — ex: diabetes, thryoid disease
- ☐ Blood / Lymph — ex: anemia, clotting disorder
- ☐ Allergic / Immunologic — ex: seasonal/food/med allergies, Lupus
- ☐ Other Health Issues — ex: cancer, other (*please describe*)

**FAMILY HISTORY** *please check any that apply to family:*

- ☐ Cancer
- ☐ Glaucoma
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Macular Degeneration
- ☐ Other Eye Disease:

**SOCIAL HISTORY** *please check any 'yes' :*

- ☐ Do you smoke? # of Packs Per Day: ______
- ☐ Do you drink alcohol? # of Drinks Per Week: ______
- ☐ Do you drive? ☐ Do you have any STDs?
- ☐ Do you use any recreational, illicit, or illegal drugs?

**WHERE WAS YOUR LAST EYE EXAM?** ☐Here **TIME SINCE LAST VISIT**

**WHO IS YOUR PRIMARY MEDICAL DOCTOR ?** **TIME SINCE LAST VISIT**

Do you take <u>any</u> medications, including eye drops? ☐Yes ☐No
*If yes, please list here:*

Do you have any allergies, including medicine reactions? ☐Yes ☐No
*If yes, please list here:*

Are you currently pregnant or nursing? ☐Yes ☐No
Have you had any injuries to your eyes in the past? ☐Yes ☐No
*If yes, please describe briefly, with dates:*

Have you had any eye surgery (including lasers)? ☐Yes ☐No
*If yes, please describe briefly, with dates:*

Have you worn contact lenses? ☐Yes, currently ☐Yes, in the past ☐No
Would you like a reminder for annual eye exams? ☐Yes ☐No
*A date and time will be reserved for your next visit. It can be changed to fit your schedule.*

**YOUR EYE DISEASE HISTORY / SYMPTOMS:** *please check any that apply to you:*

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Other Eye Disease *please describe:*
- ☐ Blurred Vision
- ☐ Eyestrain
- ☐ Headaches
- ☐ Dry Eyes
- ☐ Red Eyes
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Burning Eyes
- ☐ Flashes of Light
- ☐ Floating Spots
- ☐ Other Eye Symptoms *please describe:*

**INSURANCE INFORMATION**: *if applicable*

Medical Insurance: ______________________________ Policy/ID Number: ______________________________

Subscriber: ☐ Self ☐ Other: Subscriber's Name: ______________________________ Relationship: __________

Subscriber's Employer: ______________________________ Date of Birth: __________

Vision Plan: ☐ EyeMed ☐ Other: ______________________ Policy Number: ______________________________

Other Insurance: ______________________________ Policy/ID Number: ______________________________

*I understand that I am responsible for all charges today. In the event of denial of coverage by any insurance, I understand that I am responsible to pay for the balance due for all services rendered.*

Signature: ______________________________ Date: ______________