FIRST NAME_____ MI_____ LAST NAME_____
MAILING ADDRESS_____ CITY_____ ZIP_____
HOME PHONE_____ WORK PHONE_____
CELL PHONE_____ EMAIL_____ SEX ☐M☐F
DATE OF BIRTH_____ SOCIAL SECURITY # _____
EMPLOYER (OR SCHOOL)_____ OCCUPATION_____
SPOUSE (OR PARENT'S) NAME_____ EMPLOYED BY_____
FAMILY PHYSICIAN_____ REFERRED BY_____

PERSON RESPONSIBLE FOR ACCOUNT_____ S.S.# _____
DATE OF BIRTH_____ INSURANCE NAME_____ POLICY #_____

PERSONAL MEDICAL HISTORY

HOW IS YOUR GENERAL HEALTH ? _____

DO YOU HAVE ANY OF THE FOLLOWING ?

GLAUCOMA	☐Y ☐N	EYE INJURY	☐Y ☐N	HEART DISEASE	☐Y ☐N
CATARACTS	☐Y ☐N	EYE SURGERY	☐Y ☐N	HIGH BLOOD PRESSURE	☐Y ☐N
SKIN PROBLEMS	☐Y ☐N	LAZY EYE	☐Y ☐N	ALLERGIES	☐Y ☐N

RESPIRATORY PROBLEMS ☐Y ☐ N ENDOCRINE (GLAND) PROBLEMS ☐ Y ☐ N

ARE YOU DIABETIC?_____ IF SO, WHAT TYPE_____ YEAR DIAGNOSED_____
OTHER HEALTH PROBLEMS_____
CURRENT MEDICATIONS_____
ALLERGIES TO MEDICATIONS_____
DO YOU USE CIGARETTES/TOBACCO ?_____ ALCOHOL _____

DO YOU HAVE OR SEE ANY OF THE FOLLOWING VISUAL PROBLEMS ? (PLEASE CIRCLE)
FLASHES OF LIGHT ☐ FLOATERS ☐ SPOTS ☐ DOUBLE VISION ☐ DIZZINESS ☐
DRY EYES ☐ HEADACHES ☐ REDNESS ☐ NIGHT BLINDNESS ☐ LIGHT SENSITIVITY ☐
BLURRED VISION ☐ DIFFICULTY SLEEPING ☐

CONTACT LENS HISTORY

ARE YOU INTERESTED IN CONTACT LENSES ☐ Y ☐ N
HAVE YOU EVER WORN CONTACT LENSES ☐ Y ☐ N
IF SO, WHAT TYPE ? ☐ SOFT DAILY WEAR ☐ SOFT EXTENDED WEAR ☐ GAS PERMEABLE
WHAT SOLUTIONS DO YOU USE ?_____

FAMILY MEDICAL HISTORY

GLAUCOMA	☐ Y ☐ N	RELATION_____
CATARACTS	☐ Y ☐ N	RELATION_____
MACULAR DEGENERATION	☐ Y ☐ N	RELATION_____
RETINAL DETACHMENT	☐ Y ☐ N	RELATION_____
DIABETES	☐ Y ☐ N	RELATION_____
HEART DISEASE	☐ Y ☐ N	RELATION_____
OTHER_____		RELATION_____

I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE MY INSURANCE BENEFITS. I ALSO REQUEST THAT PAYMENT OF MY MEDICAL BENEFITS BE MADE ON MY BEHALF TO DR. MACFARLANE OR DR. RUPRECHT.

1) SIGNATURE_____ DATE_____ _____
2) SIGNATURE_____ DATE_____ _____
3) SIGNATURE_____ DATE_____ _____
4) SIGNATURE_____ DATE_____ _____
5) SIGNATURE_____ DATE_____ _____