Signed

Helfrich Family Eye Care

Guardian: _____ **Date:** 10/25/10

Name: _____ _____

Address: _____

City, St: _____ **Zip:** _____

Phone(H): _____ **(C):** _____

Date of Birth: _____ **Sex:** ____

Vision or Primary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

Medical or Secondary Insurance

Ins.: _____ **#:** _____

Insured: _____ **DOB:** _____

Relationship:

E-Mail: _____

Contact me by: ☐ Text (Web Service) ☐ Email ☐ Phone ☐ Mail

Referred by (name of friend we can thank)

☐ Friend ☐ Insurance ☐ Phone Book ☐ Other...

Occupation:

Employer: _____

Approx. Date of Last Eye Exam:

Glasses R-
L-

Contacts R-
L-

Allergies

☒ None
☐ Penicillin
☐ Sulfa
☐ Eye drops
☐ Novocain
☐ Seasonal
☐ Codeine
☐ Other...

Current Medicines

Past Medical History

☐ Ambylopia	☐ Eye infections	☐ Lazy eye	☐ Other...
☐ Arthritis	☐ Eye injuries	☐ Lupus	
☐ Asthma	☐ Eye Surgery	☐ Macular Degen.	
☐ Autoimmune	☐ Gastrointestinal	☐ Migraine	
☐ Cancer	☐ Glaucoma	☐ MS	
☐ Cataract	☐ Heart Disease	☐ Neurological	
☐ Crossed eyes	☐ High B.P.	☐ Psychological	
☐ Diabetes	☐ Keratoconus	☐ Respiratory	
☐ Droopy lid	☐ Kidney	☐ Sinus	
☐ Ear/Nose	☐ LASIK	☐ Thyroid	

Eye wear History (have you ever worn...)

☐ Glasses	☐ No- line	☐ Gas Perm	☐ Disposable
☐ Bifocals	☐ Soft Contacts	☐ Hard	☐ Overnight wear
☐ Trifocals	☐ Toric Soft	☐ Monovision	☐ Other...

Family History (parents, grandparents, siblings)

☐ Blindness	☐ Kidney Disease	☐ High B.P.	☐ Other...
☐ Cataracts	☐ Macular Degen.	☐ Thyroid	
☐ Crossed Eyes	☐ Retina Disease	☐ Glaucoma	
☐ Color Blind	☐ Retina Detach	☐ Cancer	
☐ Diabetes	☐ Heart Disease	☐ None	

Social History

☐ Computer	☐ Student	☐ Tennis	☐ Non-smoker
☐ Reading	☐ Music	☐ Shoot	☐ No alcohol or drug abuse
☐ Tobacco Use	☐ Skiing	☐ Scuba	☐ Other...
☐ Drug Abuse	☐ Golf	☐ Swim	
☐ Alcohol Abuse	☐ Fishing	☐ Bike	

Clear

Current eye problem(s) (please circle the "main" problem)

☐ Blur at Far	☐ Flashes/Floaters	☐ Other...
☐ Blur at Near	☐ Loss of vision	
☐ Blur at Far & Near	☐ Loss of side vision	
☐ Red eye	☐ Double vision	
☐ Itching	☐ Sandy/Gritty Feeling	
☐ Burning	☐ Foreign Body Sensation	
☐ Redness	☐ Spots or shadows	
☐ Eye pain	☐ Diabetes eye check	
☐ Eye strain	☐ Medical eye check	

☐ Right eye ☐ Left eye ☐ Both eyes

☐ Mild ☐ Moderate ☐ Severe

☐ Started today	☐ 3-7 days	☐ 2-4 weeks	☐ 3-6 months
☐ 1-2 days	☐ 1-2 weeks	☐ 1-3 months	☐ Over 6 months

☐ Getting better ☐ Getting worse ☐ Worse AM ☐ Worse PM

Are you interested in contact lenses information? Clear

☐ Try Contacts ☐ Upgrade Contacts ☐ No interest in Contacts

Our office requires payment at the time of service unless we "accept assignment" on your insurance. **You are responsible if your insurance does not pay. Contact lens fittings are billed separately from your eye exam.** Your information is protected by our privacy policy**.**

I have received a copy of Helfrich Family Eye Care "Notice of Privacy Practices".

Printed: 10/25/10 DOB: Signature_____ Date_____