OPTOMETRY
DR. IRA S. TUCKER
AND ASSOCIATES
THE EYE CARE SPECIALISTS

Today's date_____

PATIENT HISTORY

Name Dr./Mr./Mrs./Ms/Miss_____MI_____
Address_____City_____St_____Zip_____
Telephone (H)_____(W)_____
SSN_____-_____-_____Date of birth_____
Occupation_____E-mail_____
Employer_____
New patients: Date of last eye exam_____Last eye doctor and location_____
New patients: How did you hear of our practice? _____
Have any other members of your family been examined at this office? Y/N Name and relationship_____
_____

VISION INSURANCE INFORMATION
Vision: VSP/SAS/BCBS/Medicare Subscriber name and IDNumber_____
Patients are responsible for payment of overages, co-payments or amounts not covered by insurance.
Other insurance plans must be filed by the patient. We will be glad to provide additional receipts for this purpose.

MEDICAL INFORMATION
How is your general health?_____
Do you have problems with any of these systems? (*please circle all that apply)* Eyes Y/N

Gastrointestional	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Skin	Y/N	Allergic/immunologic	Y/N

Please explain_____
_____
Please answer all that apply:
Diabetes Y/N Type_____ Date of diagnosis_____Well Controlled Y/N
Medication Allergies Y/N Allergic to what _____
Other allergies Y/N Allergic to what? _____
Headaches Y/N _____
Other health problems_____
Current medication(s)/Vitamins_____
Have you had any operations? Y/N Kind?_____When?_____
Do you use cigarettes/tobacco? Y/N _____ Alcohol? Y/N _____ Other Substance(s) Y/N_____
Name of family doctor_____Date of last visit_____

FAMILY HISTORY
High blood pressure Y/N Relation_____ Diabetes Y/N Relation_____
Macular degeneration Y/N Relation_____ Retinal detachment Y/N Relation_____
Glaucoma Y/N Relation_____ Cataracts Y/N Relation_____
Other eye condition(s) What kind?_____Relation_____

PERSONAL EYE HEALTH INFORMATION
Have you had any eye operations? Y/N Type_____Date_____
Have you had an eye injury? Y/N Kind_____Date_____
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind?_____
Do you wear glasses? Y/N Contact lenses? Y/N Type_____
Are you interested in wearing contacts? Y/N
Additional information_____

_____

Patient: *Please date and initial _____ ; _____ ; _____ ; _____ ;
Doctor: Date and initial: _____; _____; _____; _____;