HARBOR EYE ASSOCIATES

David J. Dexter, O.D.
Stephen M. Baker, O.D.

Lori A. Youngman, O.D.
Andrew R. Larson, O.D.

Date: ______ / ______ / ______

Name: ______________________ SS# ______________________

Address: ______________ City: ______________ Zip: __________

Email: ____

Cell Ph.: __________ Work Ph.: __________ House Ph.: __________

Birthdate: _____ / _____ / __________ Age: _____ Sex: __________

School: ______________________________ Grade: __________

Employer: ____

Account Responsibility: ______________ Birthdate: ____ / ____ / _____

Address: ______________________ Phone: ______________

Employer: ______________________ Phone: ______________

Insurance: ______________________ Policy # ______________

2nd Insurance: ____________________ Policy # ______________

Vision Insurance: __________________ Policy # ______________

Primary Medical Physician: ______________________________

Last Medical Exam: ____________________________________

Last Vision Exam: _____________________________________

Who in your family have we examined? ____________________

How did you hear about us? _____________________________

(Continued on back)

Reason for this exam: __________________________________

Do you wear or have you worn eyeglasses or contacts? __________

Are you interested in contacts today? ______________________

Eye History:

Glare/Light Sensitivity Yes _____ No _____
Blurred Vision Distance Yes _____ No _____
Blurred Vision Near Yes _____ No _____
Headaches Yes ____ No ____ Discharge Yes _____ No _____
Burning Yes ____ No _____ Redness Yes _____ No _____
Dryness Yes ____ No ____ Double Vision Yes _____ No _____
Itching Yes ____ No ____ Floaters Yes _____ No _____
Flashes of light Yes ____ No ____ Eye Pain Yes _____ No _____

Do you have any medical problems?

____ Cardiovascular (High blood pressure, etc.)
____ Respiratory (Asthma, COPD, etc.)
____ Endocrine (Diabetes, thyroid, etc.)
____ Muscles, bones joints (arthritis, etc.)
____ Gastrointestinal
____ Skin
____ Allergic/Immunologic
____ Neurologic
____ Cancer
____ Other

Do you smoke? Yes _____ No _____
Do you drink alcohol? Yes _____ No _____
Do you use recreational drugs? Yes _____ No _____

Current Medications

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Past Surgery: ____

Allergies to Medications: ________________________________

Family History or eye problems? __________________________

Family History of Medical problems (High Blood Pres., Diabetes, cancer, etc.)

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