Welcome to

Eye to Eye Optometry

Intake Form

Patient Information

Name _____ M or F

Address _____ City _____ ZIP code _____

Phone _____ Email _____

Primary physician/Location _____ Date of last visit ___/___/_____

Last eye doctor/Location _____ Date of last exam ___/___/_____

Reason for today's visit _____

Insured Information

Reationship to patient ○ Self ○ Spouse ○ Parent ○ Other

Vision Insurance ○ VSP ○ EyeMed ○ Mes ○ Medicaid ○ Medicare

Member ID _____ Member Name _____ M or F

Social Security Number (last 4 #) _____ DOB ___/___/_____

Please check all the boxes that apply, unchecked boxes will mean NO

Eye History

Conditions	Yes	Surgeries	Yes
Glaucoma/Suspect		Cataract	
Cataract		Glaucoma	
Macular Degeneration		Retinal Detachment	
Uveitis		LASIK	
Retinal Detachment		Laser	
Eye Turn/Lazy Eye		Eyelid	
Trauma		Eye Injections	
Other:		Other:	

Medical History

	Yes		Yes
Diabetes		Heart Attack	
High Blood Pressure		Stroke	
Elevated Cholesterol		Cancer	
Thyroid Disorder		Asthma/COPD	
Sleep Apnea		Kidney Disease	
Pregnant - currently		Arthritis	
Nursing - currently		Other:	

Allergies

Family History

Ocular	Yes	Medical	Yes
Glaucoma		Diabetes	
Macular Degeneration		Hypertension	
Eye Turn		Cancer	
Night Blindness		Heart Disease	
Keratoconus		Migraine	
Other:		Other:	

Medications

Name	Purpose

Social History

	Yes		Yes
Smoked in the past		Drink alcohol	
Currently smoke		Recreational drug use	

Please sign below that you have reviewed all information above and that it is correct to the best of your knowledge.

Signature _____ Date ___/___/_____