Check Yearly.
See Clearly.

WELCOME TO OUR OFFICE!

Dr. PAUL P. PHOLVICHITR

"Please Print"

DATE: _____

NAME _____ _____ , _____ SEX M ☐ F ☐ AGE _____
(Last) (First) (Mi.)

ADDRESS _____
CITY / STATE / ZIP _____
HOME PHONE _____
OCCUPATION _____
WORK PHONE _____
Cell Phone: _____

BIRTHDAY _____
DRIV. LIC.# _____
EXP. DATE _____
SPOUSE _____
GUARDIAN _____
E-mail _____

HAVE YOU BEEN SEEN HERE BEFORE? Y ___ N ___ .
HAVE YOU WORN GLASSES ? Y ___ N ___ . FOR DISTANCE ___ , NEAR ___ , BOTH ___ .
HAVE YOU WORN CONTACTS ? Y ___ N ___ . TYPE ? _____
DATE OF LAST EXAM ? _____ . REFERRED BY ? _____
HAS ANYONE IN YOUR HOUSEHOLD BEEN A PATIENT OF OURS ? Y ___ N ___ .
THEIR NAME (S) _____
METHOD OF PAYMENT : CASH ___ CHECK ___ CREDIT CARD ___
DO YOU HAVE VISION INSURANCE? Y ___ N ___ . S.S.# _____
NAME OF INSURANCE COMPANY _____

YOUR REASONS FOR VISITING OUR OFFICE TODAY: (CHECK BELOW)

___ GENERAL CHECK - UP (NO SPECIFIC PROBLEM)
___ LOST OR BROKEN GLASSES
___ SCRATCHED LENSES
___ WANTS NEW GLASSES
___ BLURRED VISION
FAR ___, NEAR ___
___ HEADACHES, AM ___ , PM ___
HOW OFTEN? _____
___ DIZZY SPELLS?

___ EYES WATER
___ EYES RED
___ GLARE
___ EYES BURN
___ EYES FEEL DRY
___ EYES FEEL TIRED
___ EYES STICKY
___ PAIN IN EYES
___ SEE "SPOTS"
___ SEE "FLASHES"

___ WANT CONTACTS
___ PROBLEM WITH CONTACTS
___ OTHER _____
_____
_____
_____
_____
_____
_____
_____

HOBBIES _____

YOUR GENERAL HEALTH:

___ BLOOD PRESSURE
___ CIRCULATORY DZ
___ DIABETES
___ ARTHRITIS
___ HEART DZ
___ RESPIRATORY DZ
___ ALLERGIES
___ CANCER

YOUR EYE HEALTH,

___ CATARACTS
___ STRABISMUS
___ GLAUCOMA
___ AMBLYOPIA
___ RETINAL DZ
___ EYE INJURIES
___ EYE SURGERY
___ INFECTIONS

___ OTHER (PLEASE LIST) _____
_____

Do You Have an Allergic Reaction to Medication? If **YES**, name the medication _____
_____

HAS ANYONE IN YOUR FAMILY (BLOOD RELATIVES) HAD ANY OF THE ABOVE CONDITIONS ? Y ___ N ___
IF SO, WHAT RELATIVE AND WHAT CONDITION (S) ? _____
IF YOU ARE PRESENTLY TAKING ANY MEDICATIONS, HORMONES OR BIRTH CONTROL PILLS, PLEASE LIST :
_____

THANK YOU FOR YOUR COMPLETENESS. THIS INFORMATION IS IMPORTANT TO HELP US BETTER UNDERSTAND YOUR VISUAL NEEDS AND HEALTH STATUS.