OSSINING FAMILY OPTOMETRY

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New Patient Intake Form

Name:_____ Date of Birth:_____/_____/_____

Address:_____

City:_____State: _____Zip:_____

Social Security:_____/_____/_____

Home Phone:_____ Cell Phone:_____

Email:_____ Preferred Communication: _____

Referred By:_____

Occupation:_____

Primary Care Physician:_____

_____

Current or Previous Medical Conditions:_____

[ ] High Blood Pressure [ ] Asthma [ ] Concussion/Head Trauma [ ] Diabetes [ ]Hypothyroid

[ ] Lupus/Rheumatoid Arthritis [ ] High Cholesterol [ ] Anxiety/Depression

Current Medications:_____

_____

Allergies:_____

Last Eye Exam: _____

Previous Eye Care Professional: _____

Currently wear: [ ] Glasses [ ] Soft Contacts [ ] Hard Contacts

Previous Eye

Conditions:_____

Current or Previous Ocular Medications:_____

Family Ocular History: [ ] Glaucoma [ ] Macular Degeneration [ ] Other:_____

Current Symptoms: [ ] Blurry Vision [ ] Double vision [ ] Itchy eyes [ ] Flashes of light [ ] Red eyes [ ] Tearing

[ ] Dry eyes [ ] Floaters [ ] Eye pain [ ] Glare [ ] Fatigue [ ] Other:_____

Signature:_____ Date:_____