

**WELCOME TO THE OFFICE OF  
UNIVERSITY EYE ASSOCIATES, OD, P.A.**

Date \_\_\_\_\_

**PATIENT INFORMATION (Please Print)**

Social Security # \_\_\_\_\_

Patient's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Middle \_\_\_\_\_

What name do you prefer to be called? \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Marital Status: \_\_\_ Single \_\_\_ Married \_\_\_ Other    Spouse or Parent's Name \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ If Student: Grade/School \_\_\_\_\_

Has anyone in your immediate family been examined in this office before? Y/N If Yes, who? \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Whom may we contact in the event of an emergency? \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH INFORMATION**

Reason for examination \_\_\_\_\_

Do you wear prescription eyeglasses for:    \_\_\_ Reading    \_\_\_ Distance    \_\_\_ Both

Do you presently wear contact lenses? Y/N    If not, are you interested in contact lenses? Y/N

Are you interested in laser surgery to correct your vision? Y/N

Date of last eye exam \_\_\_\_\_ Previous eye doctor \_\_\_\_\_ Family physician \_\_\_\_\_

Medicines you are presently taking \_\_\_\_\_

Are you allergic to any medication? Y/N If yes, what? \_\_\_\_\_

Are you pregnant? Y/N If yes, how many months? \_\_\_\_\_

Please check if you or any of your immediate family have had any of the following:

	You	Family		You	Family		You	Family
Blurred Distance Vision	_____	_____	Flashes/Floaters	_____	_____	Eye Surgery	_____	_____
Blurred Near Vision	_____	_____	Color Vision loss	_____	_____	Allergies	_____	_____
Frequent Headaches	_____	_____	Crossed Eyes	_____	_____	High Blood Pressure	_____	_____
Double Vision	_____	_____	Glaucoma	_____	_____	Diabetes	_____	_____
Pain in/around eyes	_____	_____	Cataracts	_____	_____	Thyroid Problems	_____	_____

Other eye related problems or diseases \_\_\_\_\_

Have you ever had an injury in or around the eye(s) which required treatment? Y/N If yes, describe: \_\_\_\_\_

