BRODIE
OPTOMETRY

PLEASE PRINT THE FOLLOWING INFORMATION

Today's Date: _____

Last Name:	First Name:	MI:

Sex: M F	Date of Birth:	Height:	Weight:
Email:		Social Security No:	
Address:			Apt No.:
City:		State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	
Employer (or School):		Occupation (or Grade):	
Please circle appropriate status: Minor Single Married Partnered Divorced Widowed			
Please circle the race that best describes you: White African American Hispanic/Latino Asian Native American/Alaskan Native Other Decline			

If patient is a minor, parent(s)/guardian(s) Name:_____

Family Physician Name and Location:_____

Vision Insurance Carrier:	
Patient ID No.:	Group No.:
Policy Holder's Name:	Relationship: Self Spouse Child Other
Policy Holder's Date of Birth:	Policy Holder's Social Security No:
Policy Holder's Employer:	

Medical Insurance Carrier:	
Patient ID No.:	Group No.:
Policy Holder's Name:	Relationship: Self Spouse Child Other
Policy Holder's Date of Birth:	Policy Holder's Social Security No:
Policy Holder's Employer:	

How did you hear about Brodie Optometry (check all that apply):

☐ Friend or Family Member, ☐ Referral from doctor, ☐ Insurance Website,
☐ Brodie Optometry Website ☐ Social Media ☐ Drove by Office ☐ Other_____

(Please turn page over. Additional Information on back.)

Ocular/Health History

Patient name: _____ Date: _____

Please check any symptoms you are experiencing:							
	Blurred distance vision		Blurred near vision		Burning		Pain/Soreness
	Itching		Light sensitivity		Headaches		Tearing
	Eye Strain		Redness		Styes/Chalazions		Poor Night Vision
	Dryness		Halos around lights		Floaters		Flashing Lights
	Chronic eye infections		Feels like something in the eye				
	Other symptoms:						

Please check any ocular conditions:					
	Glaucoma		Macular Degeneration		Lazy/Cross eye
	Diabetic Retinopathy		Hypertensive Retinopathy		Cataracts

Do you wear glasses? _____ If yes, how old are they? _____
Do you wear contacts? _____ If yes, kind are they? _____
Are you interested in contacts?_____

Are you currently taking any medications? If so, please list:_____

Have you ever had eye surgery? If yes, please list the type and date:_____

Are you allergic to any medications? If so, please list:_____

Please check the following health conditions for which you have been treated:

___ High Blood Pressure ___ Diabetes Type 1 ___ Skin Disorders ___ Asthma/COPD
___ High Cholesterol ___ Diabetes Type 2 ___ Arthritis ___ Anxiety/Depression
___ Heart Disease ___ Digestive Dysfunction ___ Kidney Problems ___ Infections
___ Stroke ___ Hormone Dysfunction ___ HIV/AIDS
___ Blood disorders ___ Thyroid Dysfunction (Hyper/Hypo) ___ Environmental Allergies

Please list any other health problems not listed above:

Family Medical History

Please check any of the following conditions for which your blood relatives have been treated:

___ Diabetes ___ Cataracts ___ Retinal Detachment ___ Glaucoma
___ High Blood Pressure ___ Macular Degeneration ___ Lazy/Cross Eye ___ Blindness
___ Diabetic Retinopathy ___ Hypertensive Retinopathy

Social History

Do you smoke? If so, how many packs per day? _____ Are you a former smoker? _____

Do you drink alcohol on a regular basis? If so, how much?_____ Do you use recreational drugs? _____