

# Welcome To Our Office

DR. LEO DEMARCO

Optometric Physician

(Please Print)

NAME (last) \_\_\_\_\_ (first) \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ SEX M \_\_\_\_\_ F \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_ AGE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ HOME PHONE \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SS# \_\_\_\_\_

Referred By: \_\_\_\_\_ Last Eye Exam Date: \_\_\_\_\_ From Dr.: \_\_\_\_\_

Have you ever worn glasses? \_\_\_\_\_ How are they used? For Distance \_\_\_\_\_ Near \_\_\_\_\_ Constant \_\_\_\_\_

Reasons for visiting our office today. (Please check appropriate items.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> General check-up        | <input type="checkbox"/> Pain in eyes      | <input type="checkbox"/> Poor night vision              |
| <input type="checkbox"/> Lost or broken glasses  | <input type="checkbox"/> Sees "spots"      | <input type="checkbox"/> Want contact lenses            |
| <input type="checkbox"/> Blurred distance vision | <input type="checkbox"/> Eyes burn or itch | <input type="checkbox"/> Problems with present contacts |
| <input type="checkbox"/> Blurred near vision     | <input type="checkbox"/> Headaches         | <input type="checkbox"/> Other (explain) _____          |

HAVE YOU EVER BEEN EXAMINED AT THIS OFFICE BEFORE? YES \_\_\_\_\_ NO \_\_\_\_\_

YES NO

Do you take any medication? Please list: \_\_\_\_\_

Diabetic medication  Blood pressure medication  Antihistamines  Birth control pills  Premarin

Do you have any allergies? Please list: \_\_\_\_\_

Do you have heart disease? .....

Do you or any family member have diabetes? Who? \_\_\_\_\_

Do you or any family member have glaucoma? Who? \_\_\_\_\_

Do you or any family member have cataracts? Who? \_\_\_\_\_

Do you or any family member have high blood pressure? Who? \_\_\_\_\_

Do you or any family member have thyroid problems? Who? \_\_\_\_\_

Do you have arthritis? .....

Do you have HIV or AIDS? .....

Are you pregnant? .....

Do you ever see double? When? \_\_\_\_\_

Have you ever had an eye infection, injury or surgery? .....

Do you have color vision problems? .....

Have you ever worn contacts? .....

Do you now wear contact lenses? Type worn:  Gas permeable.  Disposable  Daily wear  Extended wear  Astigmatism

How old are your contacts? \_\_\_\_\_

We may need to instill drops to examine your eyes. These drops may cause some sensitivity to light and blurred vision.

I DO  I DO NOT give my permission for diagnostic drops to be used in my eyes.

PATIENT SIGNATURE \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Chief Complaint:

VA	OD 20 /	OLD Rx	OD
CC	OS 20 /	OD	OS
		OS	
SC	OD 20 /	KERATOMETRY	TECH.
	OS 20 /	OD	
		OS	
BP	COLOR	STEREO	OD _____ NCTOS _____
			TIME: AM _____ PM _____ Ta: OD _____ OS _____
PERRLA	MG	FIELDS	COVER TEST
			EOM MOTILITY
EXTERNAL		S/L	- LIDS -
		OD	- CONJ -
RET			- K -
			- A/C -
			- LENS -
SUBJ		FUNDUS	
	20 /		
	20 /		
ADD			- C/D -
			- MAC -
			- AV -
			- P -
PHOR / VERG			

**Dx**

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**Tx**

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