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 appropnate items.)

_____ General check-up	_____ Pain in eyes	_____ Poor night vision
_____ Lost or broken glasses	_____ Sees "spots"	_____ Want contact lenses
_____ Blurred distance vision	_____ Eyes bum or itch	_____ Problems with present contacts
_____ Blurred near vision	_____ Headaches	_____ 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 _____

ST7

PATIENT'S NAME: _____ DATE: _____

Chief Complaint:

VA OD 20 / OS 20 / CC	OLD Rx OD OS	OD OS
OD 20 / OS 20 / SC	KERATOMETRY OD OS	TECH.

BP	COLOR	STEREO	OD ____ NCTOS ____ TIME:	AM PM TA: OD ____ OS ____
PERRLA MG		FIELDS	COVER TEST	EOM MOTILITY

EXTERNAL RET	S/L OD	- LIDS - - CONJ - - K - - A/C - - LENS -
SUBJ 20 / 20 / ADD PHOR / VERG	FUNDUS	- C/D - - MAC - - A/V - - P -

Dx	Tx