Optometric Intake Form

1. **Please enter your information.**

First Name: _____ Middle Initials: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____

Sex:
○ Male ○ Female ○ Unknown

Social Security #: _____

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____

Zip Code: _____

Language:
○ English ○ Spanish ○ Other:

If Other for Preferred Language: _____

Occupation: _____

How did you learn about Noble Eyes?

_____

2. **Please upload an image of your drivers license card**

3. **Please enter your contact information.**

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
☐ Mobile Phone ☐ Home Phone ☐ Work Phone
☐ Email

May we leave a message?
○ Yes ○ No

4. **Demographics**

Race:
☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Decline to Answer ☐ Other:

If Other, please specify _____

Ethnicity
☐ Hispanic/Latino(a)
☐ Not Hispanic/Latino(a) ☐ Other

If Other, please specify _____

5. **Emergency Contact Information.**

Emergency Contact Name: Relationship:

Address: Apt/Unit #:

Phone Number: Alt Phone Number:

6. Family Doctor: Telephone #:

Other Health Provider: Telephone #:

Pharmacy: Telephone #:

7. **Do you have Vision Insurance?**

- ○ Yes
- ○ No

8. **Vision Insurance**

Vision Insurance Company Insured Name Member ID / Policy #

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Date of Birth

9. **Do you have Medical Insurance?**

- ○ Yes
- ○ No

10. **Primary Medical Insurance**

Primary Insurance Company Insured Name Member ID / Policy #

Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Date of Birth Insured SSN:

Do you have Secondary Insurance?
○ Yes ○ No

11. **Please upload image(s) of the front and back of your medical insurance card**

12. **Secondary Medical Insurance**

Secondary Insurance Company _____ Insured Name _____ Member ID / Policy # _____

Group Number

_____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Date of Birth _____ Insured SSN: _____

13. **Please upload image(s) of the front and back of your secondary medical insurance card**

I authorize the release of any medical information necessary to process my claim and payment of benefits.

_____ _____
Signature Date

EYE HISTORY

14. **Please indicate the date of (month/year):**

Last eye exam visit:

_____

15.

Do You Currently:	Yes	No
Wear Glasses		
Wear Contacts		

16. **What is the reason for your visit today?**

☐ Examination ☐ Emergency ☐ Other:

If other, please specify:

_____

17. Have you or a family member experienced, or been treated for, any of the the following?

	Yes	No	Family	Family Member
Cataracts				
Crossed Eye				
Glaucoma				
LASIK or RK				
Lazy Eye				
Macular Degeneration				
Retinal Detactment				

18. Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision - Near
- ☐ Blurry Vision - Distance
- ☐ Buring
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excessive Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

19. Constitution

- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other

Other Description

20. Head, Ear/Nose/Throat

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other

Other Description

21. Neurological

- ☐ Multiple Sclerosis
- ☐ Seizures/Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism Spectrum Disorder
- ☐ Other

Other Description

22. Psychiatric

- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other

Other Description

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23. Cardiovascular

- ☐ High Blood Pressure
- ☐ Stroke/TIA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other

Other Description

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24. Respiratory

- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other

Other Description

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25. Gastrointestinal

- ☐ Chron's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other

Other Description

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26. Genitourinary

- ☐ Kidney Disease/Failure
- ☐ Prostatic problems
- ☐ Venereal disease
- ☐ Benign Prostrate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Other

Other Description

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27. Musculoskeletal

- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other

Other Description

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28. Integumentary

- ☐ Exzema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/Cold Sores
- ☐ Herpes Zoster/Shingles
- ☐ Other

Other Description

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29. Endocrine

- ☐ Diabetes Type II
- ☐ Diabetes Type I
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Hormonal Disfunction
- ☐ Other

Other Description

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30. Hematological/Lymphatic

- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ HIV/AIDS
- ☐ Other

Other Description

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31. Allergic/Immune

- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other

Other Description

MEDICATIONS

32. List all medications you are taking, including any over-the-counter medications, herbs or vitamins:

	Name	Dose	Frequency	Reason for Taking?
1				
2				
3				

ALLERGIES

33. Please indicate if you have any allergies:

- ☐ No Known Drug Allergies
- ☐ Aspirin
- ☐ Acrylic
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Metal
- ☐ Penicillin
- ☐ Sulfa Drugs
- ☐ Other:

If other, please specify:

_____

PREGNANCY AND NURSING

34. Are you pregnant?
○ Yes ○ No ○ N/A

If yes, how many weeks?

_____

Are you breastfeeding?
○ Yes ○ No ○ N/A

ENVIRONMENT AND HEALTH

35. Do you use tobacco?

- ○ Yes
- ○ No

Description (i.e. Cigarettes, Pipe)

_____

36. Have you ever used tobacco?

- ○ Yes
- ○ No

37. Smoking Status

- ○ Current every day
- ○ Current some days
- ○ Former smoker
- ○ Never Smoker
- ○ Smoker, current status unknown
- ○ Unknown, if ever smoked

38. Do you drink alcohol?
○ Yes ○ No

Hobbies:

_____

_____

Hours of Computer/Phone/Screen User per Day:

_____