Dr. Danny P. Malone, O.D.

Welcome to Our Office

Today's Date _____
Last _____ First _____ MI ____
Street _____
City _____ State _____ Zip Code _____
Home Phone _____
Work Phone _____
Patient's Social Security Number: _____
Employer (or School): _____
Occupation (or Grade): _____
Spouse (or Parent's Name): _____
Spouse (or Parent's Work): _____
Date of Birth: _____ Age _____ Sex M F
Email address _____

What is the major purpose of this visit?

_____

Any problems with your present contact lenses or glasses?

_____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office for your needs?

○ Another Dr. ○ Insurance List
○ Saw Sign/Building ○ Newspaper/Radio/TV
○ Yellow Pages. Which directory?
○ Web Page. Which Web site? _____
○ Other. _____

Insurance Information

Vision Insurance: _____
Subscriber Name: _____
Subscriber Social Security Number: _____
Patient's Birth date: _____

_____

Primary Medical Insurance: _____
Subscriber Name: _____
Subscriber Social Security Number: _____
Do you participate in a flex spending account? ○ Yes ○ No
How will you settle your account today?
○ Check ○ Cash ○ Credit Card

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

	Relationship
Blindness	○ _____
Cataracts	○ _____
Corneal Problems	○ _____
Glaucoma	○ _____
Lazy Eye	○ _____
Macular Degeneration	○ _____
Retinal Problems	○ _____
Diabetes	○ _____
Heart Disease	○ _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____
Town _____
Date of Last Physical Check-up _____

_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins & birth control pills) _____

_____

_____

Allergies to Medications: ○ Yes ○ No

_____

_____

Have you ever been diagnosed or treated for the following?

○ Allergies	○ Diabetes	○ Thyroid
○ Asthma	○ Heart Disease	○ Tobacco
○ Arthritis	○ High Blood Pressure	○ Alcohol
○ Cancer	○ Kidney	○ Other substances
○ Cholesterol	○ Nerves	_____

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____
Do you currently wear contact lenses? ○ Yes ○ No
What kind? _____
Solutions Used _____
Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____
Have ever tried contact lenses? ○ Yes ○ No

Do you... (Check box if your answer is yes)

○ Work at a computer?
○ Think you might benefit from thinner, lighter lenses?
○ Have interest in a "Test Drive" of the latest in contact lens design?
○ Spend time outdoors? (how much)? _____ hrs/wk
○ Have prescription sunglasses?
○ Prefer not to wear your glasses at times?
○ Want information on Laser Vision Correction surgery?
○ Have interest in a non-surgical approach to vision correction?
○ Have more than 1 pair of current Rx glasses?
○ Have children?
○ Have family members in need of eyecare?

If you wear bifocals, are you bothered by the lines or head tilting?
○ Yes ○ No

If you wear contact lenses, are you satisfied with the vision and comfort? ○ Yes ○ No

Have you ever been diagnosed or treated for the following?

○ Cataracts	○ Iritis/Uveitis
○ Corneal Abrasion	○ Lazy Eye
○ Eye infection	○ Macular Degeneration
○ Eye injury	○ Retinal Detachment
○ Glaucoma	○ Other eye disorders

Do you experience or have you ever experienced?

○ Blurry vision	○ Flash of light	○ Sunlight sensitivity
○ Burning	○ Floaters/spots	○ Tearing
○ Crossed eye/eye turn	○ Grittiness	○ Trouble seeing at night
○ Double vision	○ Headaches	○ Uncomfortable glasses
○ Occasional Dryness	○ Itchiness	