

BOTWIN EYE GROUP

e y e s & o p t i c s

date _____
name _____ date of birth _____ age _____
social security number (required if billing insurance) _____ gender: male female
home address _____
city _____ state _____ zip _____

TELEPHONE NUMBERS:

home _____ cell _____ work _____
email address _____
preferred method of contact: home phone cell phone work phone email
employer _____ occupation _____
emergency contact _____ relationship _____
how were you referred? family friend existing patient phone book website insurance company
 other _____
do you have a vision plan? yes no company _____
do you have medical insurance? yes no company _____

PLEASE GIVE INSURANCE CARDS TO RECEPTIONIST

Vision Plans cover "well vision" exams. Any medical history or diagnosis that can affect the eyes will result in the visit being billed to your medical insurance.

date of last eye exam _____ doctor _____
last physical exam _____ your primary care physician _____

OCCUPATIONAL VISION CONCERNS

at work do you perform extensive up-close work? yes no
does your job require safety glasses? yes no
are you outdoors all or much of the time? yes no
how much time do you spend on a computer daily? (circle one) none 3-6 hours more than 6 hours

CURRENT EYEWEAR STATUS

glasses worn: never constantly for distance for reading
how many pairs of prescription glasses do you own? _____
do you wear bifocals? yes no trifocals yes no progressives (no line) yes no
do you have a pair of computer glasses? yes no
do you have a pair of sunglasses? yes no are they prescription? yes no Polarized? yes no

Optometric Physicians
DR. MARK A. BOTWIN
DR. JONATHAN D. BOTWIN
505.954.4442
www.BotwinEyeGroup.com

CONTACT LENS USE

years _____ soft rigid do you sleep in your contacts? yes no
brand of contact lens _____ solution brand _____ age of contacts _____

FAMILY (not you) HEALTH HISTORY (check if yes)

cancer high blood pressure diabetes heart disease stroke glaucoma cataract
 macular degeneration other _____

PERSONAL HEALTH HISTORY (check if yes)

do you have any of the following eye symptoms? (check if yes)

itching eyes tearing/redness/discharge light sensitivity eye pain dry eyes seeing floaters
 light flashes eyelid swelling blurred vision history of strabismus (crossed eyes)
 other eye symptoms _____

are you using any eye drops or other eye medications? If yes, list _____

eyes

all negative
 glaucoma
 cataract
 macular degeneration
 surgery
 other _____
 medications _____

allergic/immunologic

all negative
 drug allergy
 environmental allergy
 rheumatoid arthritis
 lupus
 other _____
 medications _____

gastrointestinal

all negative
 crohn's
 colitis
 ulcer
 digestive
 other _____
 medications _____

integumentary

all negative
 eczema
 rosacea
 psoriasis
 other _____
 medications _____

psychiatric

all negative
 depression
 panic disorder
 bipolar
 other _____
 medications _____

cardiovascular

all negative
 heart disease
 hypertension
 stroke
 other _____
 medications _____

endocrine

all negative
 non insulin dependent
 diabetes
 insulin dependent diabetes
 thyroid dysfunction
 hormonal dysfunction
 other _____
 medications _____

musculoskeletal

all negative
 fibromyalgia
 muscular dystrophy
 osteoarthritis
 ankylosing spondylitis
 other _____
 medications _____

genitourinary

all negative
 STD-viral herpetic, chlamydia
 other _____
 medications _____

respiratory

all negative
 cigarette smoker
 asthma
 bronchitis
 emphysema
 other _____
 medications _____

constitutional

all negative
 developmental disability
 weight loss
 fatigue
 trauma
 other _____
 medications _____

hematologic/lymphatic

all negative
 anemia
 leukemia
 cancer
 HIV
 other _____
 medications _____

ears, nose, throat

all negative
 upper resp. infection
 other _____
 medications _____

neurological

all negative
 multiple sclerosis
 epilepsy
 other _____
 medications _____

alcohol use

yes
 no
 occasional

tobacco use

yes
 no
 occasional

marijuana use

yes
 no
 occasional

Thank you for filling out this form completely

updated date _____ initials _____