DR. LATISHA PATEL, O.D. & ASSOCIATES

Welcome to our office. Please take a moment to complete the following information:

Last Name: _____ First Name: _____ D.O.B: _____ Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Emergency Number: _____

How were you referred to our office? _____

WHAT IS THE MAIN REASON FOR TODAY'S EXAM (check all that apply):

Yearly Eye Exam		Blurry Vision (Near)		Blurry Vision (Distance)	
Floaters or Spots		Headaches		Dryness	
Infection of Eye/Lid		Itching		Redness	
Burning		Tearing		Other:	

MEDICAL HEALTH HISTORY

HAVE YOU OR ANY FAMILY MEMBER BEEN DIAGNOSED WITH (check all that apply):

CONDITION	SELF	FAMILY	WHO
Glaucoma			
Cataracts			
Macular Degeneration			
Retinal Detachment			
Lazy Eye			
Cardiovascular (Hypertension)			
Stroke			
Endocrine (Diabetes, Thyroid)			
Respiratory (Asthma)			
Arthritis			
Cancer			
Other			

Have you ever had your eyes dilated? **Y N** If so, when _____

Would you like to have your eyes dilated? **Y N**

Do you have any allergies? **Y N** Please specify: _____

List **ALL** current medications and eye drops: _____

_____

Have you had any eye surgeries? **Y N** Specify: _____ Are you Pregnant? **Y N** Nursing? **Y N**

How many hours a day do you use the computer? _____ What are your hobbies? _____

Do you currently wear contact lenses? **Y N** What Brand? _____

Are you interested in a contact lens exam today? **Y N**

My signature below includes acknowledgement of NOTICE OF PRIVACY PRACTICES of Dr. Latisha Patel, OD & Associates.

Signature: _____ Date: _____