

John C. Fleming, O.D.

Doctor of Optometry

Thank you for choosing our practice for your eyecare needs. Our objective is to provide you the best in vision care. Please fill in all of the spaces. If you have any questions or concerns regarding this form, our staff will be happy to help you.

Member



American Optometric Association

PATIENT INFORMATION

Patient Name _____ Date of birth: _____ Age _____

Address: _____ City: _____ ST: _____ Zip _____

Occupation: _____ Employer: _____ Work #: _____

Home #: _____ Cell #: _____ Email: _____

Vision Ins: _____

Major Medical Insurance: _____

How did you hear of our office? Family ___ Friend ___ Doctor ___ Yellow Pages ___ Website ___ Insurance ___

HEALTH HISTORY

Today's examination is for: Routine Examination ___ Eyeglasses ___ Contact Lenses ___ Laser Vision Care ___

Other _____

Date of last eye examination _____ with Dr. _____

Are you taking medication? ___ Yes ___ No If yes, please list: _____

Do you have any allergies to medication? ___ Yes ___ No If yes, what are you allergic to? _____

Do you or anyone in your immediate family have a history of the following? S=Self F=Family

Diabetes ___ Thyroid Condition ___ High-blood Pressure ___ Cataract ___ Glaucoma ___ Macular Degeneration ___

CURRENT VISION PROBLEMS

Blur at distance with glasses _____

Frequent headaches _____

Blur at near with glasses _____

Eyes burn, itch, water _____

Blur at distance without glasses _____

Sensitivity to light _____

Blur at near without glasses _____

Difficulty seeing at night _____

How many hours per day do you use a computer? _____

Have you ever worn contact lenses? Yes ___ No ___ If yes, what type? _____

Last time worn? _____ Problems? _____

Are you interested in contact lenses? ___ Yes ___ No What type? _____

Are you interested in laser eye surgery? ___ Yes ___ No

Signature _____ Date _____