EDMOND FAMILY EYE CARE

Matthew E. Morris, OD • Tracy E. Morris, OD

PATIENT INFORMATION

_____	_____	_____	_____	_____	____ /____/ ____
Salutation	First Name	MI	Last Name	Suffix	DOB

_____ _____ _____
e-mail address Patient's occupation Patient's employer

_____ _____
Spouse's name (if applicable) Spouse's employer (if applicable)

Is this your first visit to our office? □ Yes □ No If yes, please tell us who referred you: _____

Please tell us the reason(s) for your upcoming visit: (check all that apply)
□ Exam □ Glasses □ Contact Lenses □ Eye Infection/Injury
□ Laser Vision Consultation □ Medical Problem □ Other - If other please explain:_____

WELCOME TO OUR OFFICE

Welcome to Edmond Family Eye Care! We appreciate having you as a patient at our office. As your eye care provider, we hope to not only meet, but exceed your expectations. We pride ourselves on service and quality. If there's anything you would like to see, just let us know. We want your feedback!

PAYMENT POLICY – PLEASE READ CAREFULLY

FEES FOR PROFESSIONAL SERVICES ARE DUE WHEN SERVICES ARE RENDERED.
When materials are necessary (glasses or contact lenses), payment in full is due at the time of ordering. All sales are final on prescription eyewear and contact lenses. All newly purchased eyewear is under a one year warranty unless otherwise noted. Should your account become delinquent and require legal collection efforts on behalf of our collection agency or settlement via small claims court, a "delinquent account fee" will be added to your account balance. The "delinquent account fee" is $25.00 plus 30% for collection costs. The returned check fee is $25.00.

I have read, understand and agree to the above terms and understand that I am responsible for any fees incurred.

_____	_____	_____	_____
Signature of Patient, Parent or Guardian	Printed name of Patient, Parent or Guardian	Relationship to patient	Date

MEDICAL HISTORY

To help our office better serve your specific needs, please check all that apply to you. Please leave boxes unchecked for a "no" answer.

EYE HISTORY

Date of last eye examination:____/____/____ Name of doctor:_____

- ☐ Headaches
- ☐ Eye Infection
- ☐ Drooping Eyelid
- ☐ Crossed Eyes (Strabismus)
- ☐ Floaters or Spots
- ☐ Loss of Side Vision
- ☐ Macular Degeneration
- ☐ Color Blindness
- ☐ Amblyopia (lazy eye)
- ☐ Double Vision
- ☐ Cataract(s)
- ☐ Glare/Light Sensitivity
- ☐ Excess Tearing/Watering
- ☐ Sandy or Gritty Feeling
- ☐ Blurred Vision – Distance
- ☐ Blurred Vision -Near
- ☐ Foreign Body Sensation
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Eye Pain/Soreness
- ☐ Distorted Vision
- ☐ Eye Surgery
- ☐ Tired Eyes
- ☐ Redness
- ☐ Itching
- ☐ Dryness
- ☐ Burning
- ☐ Loss of Vision
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Fluctuating Vision
- ☐ Mucous Discharge
- ☐ Poor Color Vision

GENERAL HEALTH

Primary Care Physician:_____

- ☐ AIDS/HIV
- ☐ Allergic Disorders
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Cholesterol, Elevated
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Heart Condition
- ☐ Hepatitis (Type_____)
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Pregnant/Nursing
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Thyroid Conditions
- ☐ Tuberculosis
- ☐ Other _____

FAMILY HISTORY

Please check the box(es) if any of your blood relatives had any of the following conditions:

- ☐ Stroke
- ☐ Amblyopia (Lazy Eye)
- ☐ Glaucoma
- ☐ High Blood Pressure
- ☐ Color Blindness
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Lupus
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Heart Disease
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Crossed Eyes (Strabismus)
- ☐ Cataract(s)
- ☐ Blindness
- ☐ Other

SOCIAL HISTORY

Do you smoke or use smokeless tobacco products? ☐ Yes ☐ No If yes, how many packs/day?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/week?_____

MEDICATIONS List any medications you are currently taking, including over-the-counter medications and eye drops.

_____

_____

_____

ALLERGIES List your allergies to medications or other substances.

_____

_____

_____