

WELCOME TO OUR OFFICE

Donald W. Mitchell, O.D., FAAO

Name _____ Today's Date _____ Date of Last Exam _____

Street _____ Date of Birth _____ Age _____

City _____ State _____ Zip _____ Sex: M F

Home phone _____ Work phone _____

Employer (or school) _____ Spouse (or parent) name _____

Occupation (or grade) _____ Spouse (or parent) work phone _____

E-mail address _____ Insurance Name/ID#: _____

May we contact you via email with our newsletter or contact lens information? Yes No

PERSONAL MEDICAL INFORMATION

Family Physician Name _____

Last Seen _____

Allergies No Yes

Asthma No Yes

Arthritis No Yes

Cancer No Yes

Cataracts No Yes

Cigarette Use No Yes

Current No Yes

Previous No Yes

Alcohol Use No Yes

Other Substances No Yes

Diabetes No Yes

Lazy Eye No Yes

Eye Injury No Yes

Eye Surgery No Yes

Glaucoma No Yes

Heart Disease No Yes

High Blood Pressure No Yes

Kidney No Yes

Nerves No Yes

Seizures No Yes

Skin Disorder No Yes

Stroke No Yes

Thyroid Disorder No Yes

Other _____

FAMILY MEDICAL HISTORY

Cataracts No Yes Relationship _____

Glaucoma No Yes _____

Diabetes No Yes _____

Heart Disease No Yes _____

High Blood Pressure No Yes _____

Other _____

CURRENT MEDICATIONS (RX or over-the-counter)

Antibiotics No Yes Name of Medication _____

Antihistamines No Yes _____

Diuretics ("water pills") No Yes _____

High Blood Pres pills No Yes _____

Oral Contraceptives No Yes _____

Sleeping Tablets No Yes _____

Vitamins No Yes _____

Other Meds _____

What is the major purpose of your visit to our office?

What other family members are patients here?

Any problems with your current glasses or contact lenses?

List any hobbies/recreational activities you are involved in:

List any occupational needs (safety or computer glasses):

How did you first hear about Dr. Mitchell?

_____ Referred by friend/relative

If so, who? _____

_____ Referred by health care practitioner

If so, who? _____

_____ Yellow Pages

_____ Civic Group/Community Event

_____ Newspaper Advertisement

_____ Office Signage

_____ Other _____

Do you have problems with glare from night driving, computer use,
or fluorescent lights? Yes No

Are you light sensitive? Yes No

Are you interested in contact lenses? Yes No

Are you interested in color contacts? Yes No

Have you ever worn or currently wear contact lenses? Yes No

What kind? _____ Solution used: _____

Are you interested in laser vision correction surgery? Yes No

Are you interested in sunglasses? Yes No