# Office Information

Name ______________________________ Date ____________________

Address ______________________________ Birth Date ______________ Age _____

City ______________ State _____ Zip ______________ Sex: M F SS# ____________________

Home Phone ______________ Work Phone ______________ Responsible Party ____________________

Cell Phone ______________ Email ______________ Employer ____________________

**Payment Policy:**
Examination fees are due at date of service. Material purchases require a 50% deposit and the balance is due on delivery.

A $25 charge for all returned checks will apply.
We will bill your insurance as a convenience for you, but the charges incurred are your responsibility.

**Method of Payment:**
___Cash ___Credit Card ___ Check

**Insurance:**

Vision ____________________

Medical ____________________

MEDICAL HISTORY

| | Self | Family |
|---|---|---|
| Cataract | ________ | ________ |
| Glaucoma | ________ | ________ |
| Retinal Detachment | ________ | ________ |
| Macular Degeneration | ________ | ________ |
| Eye Infection | ________ | ________ |
| Eye Injury | ________ | ________ |
| Turned or Lazy Eye | ________ | ________ |
| Drooping Eyelid | ________ | ________ |
| Dry Eye | ________ | ________ |
| Diabetes | ________ | ________ |
| High Blood Pressure | ________ | ________ |
| Thyroid Disease | ________ | ________ |
| Cancer | ________ | ________ |
| Other | ________ | ________ |

Family Physician ____________________
Previous Eye Dr. ____________________
Date of last eye exam ____________________
Current Medications ____________________
____________________
Medication Allergies: ____________________

I am interested in:
______ Contact Lenses ______ Glasses
______ Refractive Surgery ______ Other
______ Sunglasses

Currently wearing contact lenses? Yes No
Type/Brand ____________________
Solutions ____________________

Reason for today's exam? ____________________

____________________

What hobbies or sports do you participate in?

____________________

Referred by: ____________________

I hereby authorize my insurance benefits to be paid directly to Dr. Dale Rowe. I also agree to the release of any required information and understand that I am financially responsible for any and all non-covered services.

______________________________ ____________________
Signature Date

OVER

## Review of Systems

Do you currently, or have you ever had any problems in the following areas:

| SYSTEM | YES | NO |
|---|---|---|
| CONSTITUTIONAL (fever, weight gain/loss) | | |
| INTEGUMENTARY (skin) | | |
| NEUROLOGICAL | | |
| Headaches | | |
| Migraines | | |
| Seizures | | |
| EYES | | |
| Loss of vision | | |
| Blurred vision | | |
| Distorted vision/halos | | |
| Loss of side vision | | |
| Double vision | | |
| Dryness | | |
| Mucous discharge | | |
| Redness | | |
| Sandy or gritty feeling | | |
| Itching | | |
| Burning | | |
| Foreign body sensation | | |
| Excess tearing/watering | | |
| Glare/ light sensitivity | | |
| Eye pain or soreness | | |
| Chronic infection of eye or lid | | |
| Sties or chalazion | | |
| Flashes or floaters in vision | | |
| Tired eyes | | |

| | YES | NO |
|---|---|---|
| EAR, NOSE, MOUTH THROAT | | |
| Allergies/ Hay fever | | |
| Sinus congestion | | |
| Chronic Cough | | |
| RESPIRATORY | | |
| Asthma | | |
| Chronic Bronchitis | | |
| Emphysema | | |
| CARDIOVASCULAR | | |
| Diabetes | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| Congestive heart failure | | |
| BONES/ JOINTS/ MUSCLES | | |
| Rheumatoid arthritis | | |
| Muscle/ joint pain | | |
| LYMPHATIC/ HEMATOLOGIC | | |
| Anemia | | |
| Bleeding problems | | |
| ENDOCRINE | | |
| Thyroid or other glands | | |
| IMMUNOLOGIC/ ALLERGIC | | |
| HIV positive | | |
| MENTAL HEALTH | | |
| depression/ anxiety | | |

## Social History:

This information is strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my social history information directly with my doctor. (check box)

Do you drive? no yes If yes, do you have difficulty when driving? no yes ____________________________

Do you use tobacco products? no yes Type/ amount / how long: ________________________________________

Do you drink alcohol? no yes Type/ amount / how long: ______________________________________________

Do you use illegal drugs? no yes Type/ amount / how long: ___________________________________________

Are you pregnant or nursing? no yes

Have you ever been exposed or infected with: Hepatitis HIV Syphilis Chlamydia

Name ________________________________ Date ________________