



JENNIFER L. BROOKS, O.D.
MATTHEW P. BROOKS, O.D.
SAMUEL C. OLIPHANT, O.D., F.A.A.O.

Chart # _____

Please print in blue or black ink.

Patient Name: _____ Preferred Name: _____ Age: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home phone: _____ Cell phone: _____ Business Phone: _____
E-Mail address: _____ Date of Birth: _____ Gender: M / F SSN: _____
Marital Status: (Circle one) Single Married Divorced Legally Separated Widowed
Occupation: _____ Employer: _____
Spouse's Name _____ Occupation: _____ Place of employment: _____

Who may we thank for referring you to our practice? _____
Reason for today's visit: _____
Do you have any specific questions for your doctor today? _____

Are you planning on new eyeglasses today? Y / N / Maybe Are you planning on purchasing contacts? Y / N
If not a contact lens wearer, are you interested in trying contacts today? Y / N / Maybe
Are you interested in learning more about laser vision correction? Y / N

Contact Lens History:

Do you currently wear contact lenses? Y / N Hours per day: _____ Days per week: _____
Brand you are currently wearing? _____ Today's wearing time? _____ Age of current lenses? _____
If not wearing contacts now, have you tried them in the past? Y / N Reason for discontinued wear? _____

Glasses History:

Do you currently wear glasses? Y / N (Circle One) Full-time Part-time Distance Part-time Near
Glasses currently worn: (Circle One) Single Vision Bifocals Progressive Trifocals
How old were you when glasses were first prescribed? _____
Do you wear sunglasses: Y / N Are your sunglasses your most recent prescription? Y / N
Do you have any hobbies or jobs that require special glasses or contacts? _____

Other Visual History:

From whom did you receive your last eye examination? _____ Date of last exam: _____
Why did you leave their practice? _____
Have you had any: Head injuries? Y / N Head/Eye surgeries? Y / N Illnesses involving eyes or head: Y / N
Do you have headaches? Y / N How often? _____ Location? _____ What relieves the headache? _____
Which describes your headache? (Circle all that apply) Dull Throbbing Aching Constant Sharp Other _____

Social History:

Use of Alcohol: None _____ Social use only _____ 1-2 drinks daily _____ Above average use _____ Alcohol dependence _____
Use of Tobacco: None _____ Former smoker _____ Light smoker _____ Average smoker _____ Heavy smoker _____
Use of Narcotic: None _____ Type & frequency _____
Sexually Transmitted Disease: Y / N If yes, name kind of STD _____ HIV Positive? Y / N

Family Members:

Please list your family members:					
Name/Relationship to you	Age	Last Eye Exam	Name/Relationship to you	Age	Last Eye Exam

Current Medications

1. _____ for _____
2. _____ for _____
3. _____ for _____
4. _____ for _____
5. _____ for _____
6. _____ for _____
7. _____ for _____
8. _____ for _____
9. _____ for _____
10. _____ for _____

Drug Allergies: Y / N Please list: _____

Ocular History

Please list all ocular surgeries:

Procedure: _____ Year: _____ Eye: R / L Dr. _____

Procedure: _____ Year: _____ Eye: R / L Dr. _____

Procedure: _____ Year: _____ Eye: R / L Dr. _____

Current Eye Symptoms/Conditions: (check all that apply)

Headaches	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	Blurred Distance Vision	<input type="checkbox"/>	Problems driving at night	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	Eye Pain/Soreness	<input type="checkbox"/>	Blurred Near Vision	<input type="checkbox"/>	Poor reading comprehension	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	Sandy/Gritty Feeling	<input type="checkbox"/>	Fluctuating Vision	<input type="checkbox"/>	Head tilt	<input type="checkbox"/>
Amblyopia/Lazy Eye	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Fluorescent light sensitivity	<input type="checkbox"/>
Burning	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Others (Please list):	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>		<input type="checkbox"/>
Itching	<input type="checkbox"/>	Floater	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>		<input type="checkbox"/>
Redness	<input type="checkbox"/>	Flashes of Light	<input type="checkbox"/>	Skipping lines when reading	<input type="checkbox"/>		<input type="checkbox"/>

Medical History

Indicate any personal history below: (check all that apply)

Cardiovascular	Integumentary	Musculoskeletal	Genitourinary
Congestive Heart Failure <input type="checkbox"/>	Acne Rosacea <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Menopause <input type="checkbox"/>
Elevated Cholesterol <input type="checkbox"/>	Lupus <input type="checkbox"/>	Rheumatoid Arthritis <input type="checkbox"/>	Prostate Cancer <input type="checkbox"/>
High Blood Pressure <input type="checkbox"/>	Psoriasis <input type="checkbox"/>	Neurological	Cervical Cancer <input type="checkbox"/>
Stroke <input type="checkbox"/>	Dizziness <input type="checkbox"/>	Bell's Palsy <input type="checkbox"/>	Breast Cancer <input type="checkbox"/>
Endocrine	Hematologic/Lymphatic	Brain Tumor <input type="checkbox"/>	Head/ENT/Dental
Diabetes <input type="checkbox"/>	Leukemia <input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/>	Chronic Cough <input type="checkbox"/>
Gout <input type="checkbox"/>	Lymphatic Disorder <input type="checkbox"/>	Parkinson's Disease <input type="checkbox"/>	Migraines <input type="checkbox"/>
Thyroid (High or Low) <input type="checkbox"/>	Sickle Cell Disease <input type="checkbox"/>	Seizures <input type="checkbox"/>	Sinusitis <input type="checkbox"/>
Renal Disease (Kidney) <input type="checkbox"/>	Temporal Arteritis <input type="checkbox"/>	Psychiatric	Dizziness <input type="checkbox"/>
Gastrointestinal	Immunologic	Alzheimer's <input type="checkbox"/>	Respiratory
Cancer: Colon, Liver <input type="checkbox"/>	AIDS <input type="checkbox"/>	Bipolar Disorder <input type="checkbox"/>	Asthma <input type="checkbox"/>
Colitis <input type="checkbox"/>	Sarcoidosis <input type="checkbox"/>	Depression <input type="checkbox"/>	COPD <input type="checkbox"/>
Hepatitis <input type="checkbox"/>	Sjogren's Syndrome <input type="checkbox"/>	Learning Disability <input type="checkbox"/>	Emphysema <input type="checkbox"/>
Inflammatory Bowel Disease <input type="checkbox"/>	Syphilis <input type="checkbox"/>	Schizophrenia <input type="checkbox"/>	Lung Disorder <input type="checkbox"/>
GERD (Acid Reflux) <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Anxiety Disorder <input type="checkbox"/>	Lung Cancer <input type="checkbox"/>

Family Physician:

Name: _____ Phone: _____ Date of Last Physical Exam: _____

Family History: (check all that apply)			
Condition	Relationship to Patient	Condition	Relationship to Patient
Amblyopia/Lazy Eye		Cancer	
Blindness		Diabetes	
Cataracts		Heart Disease	
Glaucoma		Stroke	
Retinal Detachment		Thyroid Disease	
Macular Degeneration		Other	

Other information:

Would you like more information concerning the following: (check all that apply)			
Contact Lenses	Integrated Learning	Occupational Lenses/Frames	
Visually-Related Learning Disabilities	Sports Lenses/Frames	Lazy/Crossed Eye Therapy	
Lens/Frame Advances	Vision and Reading Problems	Dry Eye Treatment	
Computer Vision Syndrome	Laser Correction	Infant Visual Care	
Sports Vision	Lectures/Workshops	Vision Therapy	

Please check your activities/hobbies:					
Baseball	Fishing	Needlepoint	Softball		
Basketball	Gardening	Painting	Swimming		
Boating	Golf	Racquetball	Television		
Card Playing	Handball	Reading	Tennis		
Carpentry	Hunting	Repair, Home	Water skiing		
Crafts	Knitting	Sewing	Whittling		
Computers	Model Making	Shooting	Woodworking		
Drawing	Nature Study	Snow skiing	Other		

Has your vision been a problem for you in any sport or hobby? _____

Thank you for completing the above questionnaire. A comprehensive history allows us to better meet your needs.

Payment Policy

- Payment:** Payment is expected at the time services are received. A deposit of 50% is required prior to ordering glasses, contact lenses, or other materials.
- Credit:** Our office accepts Visa, Mastercard, American Express, Discover, and Care Credit.
- Insurance:** We are not participating providers for any insurance companies. Therefore, payment is required to us at the time of service, and we will provide you the necessary paperwork for you to file your own insurance claim if you choose to do so. Your insurance company will reimburse you directly for the portion they are contracted to pay, *which may not be the full amount of the examination.*

A finance charge of 1.5% will be charged each month on any unpaid balance. (18% annual)

Please circle the method of payment for today's services: Check Credit Card Cash

Signature

Date