

PREMIER VISION GROUP
PATIENT HISTORY FORM

DATE _____ PATIENT NAME _____ MALE FEMALE

If you are a new patient to our office, who can we thank for referring you, or how did you decide to visit our office? _____

1. What is the major reason for having your eyes examined?
 - Routine Exam
 - Wish to purchase new eyeglasses, sunglasses because _____
 - Wish to purchase contact lenses
 - Problems with old contacts? _____ dryness _____ poor vision _____
 - Wish information about lasik eye surgery
 - Decrease in distance vision ▪ decrease in near vision
 - Eyestrain ▪ Headaches
 - Other Reason; Please explain _____
2. Do you currently wear: _____ eyeglasses _____ contacts?
3. Please list any questions or concerns that you have that you would like addressed today:

4. If you are new to our office, when was your last eye exam? _____
5. Have you ever had any eye surgery or serious eye injury or problem with your eyes?

6. List any general health problems you have. Circle all that apply: diabetes, high blood pressure, high cholesterol, cancer, glaucoma, other problems: _____
7. Please list any medications you are taking and the dosages: _____
8. Do you have any drug allergies? _____
9. Insurance companies and Medicare require us to ask if you smoke or consume alcoholic beverages. Circle which apply (optional) smoker alcohol
10. Do you have any family history of (Circle if applies): glaucoma, diabetes, high blood pressure, other

