PATIENT FOLLOW-UP FORM

Name: _____ D.O.B: _____ Date: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer/Occupation: _____

Email: _____

Do you have vision insurance? ☐No ☐Yes

If Yes, Provider? _____

Do you have health insurance? ☐No ☐Yes

If Yes, Provider? _____

Do you have medicare? ☐No ☐Yes

Medical History

Date of last eye exam: _____

By Whom: _____

Who is your family doctor? _____

Do you have any allergies to medication? ☐No ☐Yes If yes, explain:

_____

_____

_____

List medications you take (including oral contraceptives, aspirin, over-the-counter meds, and home remedies): _____

_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had:

_____

List any of the following that you have had - crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, or eye injury:

_____

_____

Are you pregnant and/or nursing? ☐No ☐Yes

Do you wear glasses? ☐No ☐Yes

If yes, how are your lenses? _____

Do you wear contact lenses? ☐No ☐Yes

If yes, how are your lenses? _____

Contact lens type:

☐Rigid ☐Soft ☐Extended Wear ☐Other Are they comfortable? ☐No ☐Yes

Contact lens disinfection type: _____

Reviewed Family & Social History from ____/____/____ reviewed ☐ No Changes

Dr. Initials _____

Re-Order Item# 9907015

Follow-up Exam Form