

Welcome to Golden Triangle Optometric Center

Thank you for choosing our office for your eye care needs. We are pleased to have you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the following important information. If you have questions, please don't hesitate to ask.

Name _____ Birthdate ____ / ____ / ____ SSN _____

Address _____ Apt. # _____ City _____ State _____

Zip Code _____ Home Phone _____ Work Phone _____

Cell Phone _____ Employer _____ Occupation _____

Hobbies _____

E-Mail _____ Marital Status _____

Who may we thank for referring you to our office? Insurance Online Patient Referral Walk-in

If patient referral, please provide his/her name _____

What is the main reason for your visit today? _____

Do you wear any Contact lenses? YES / NO If yes, please specify type/brand: _____

Do you have any of the following Medical Conditions? ***Please check all that apply.***

Anxiety	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Hyperthyroidism	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
GERD	<input type="checkbox"/>	Other	<input type="checkbox"/>

Please specify other medical conditions (*if applicable*): _____

Do you have any allergies to any medications? YES / NO If yes, please list: _____

Please list any **current medications** including over the counter medications you are taking:

Do you currently have any of the following eye conditions? Check the box if "Yes."

- Glasses Dryness Itching Glaucoma
 Contacts Sandy or Gritty Feeling Redness Allergic Conjunctivitis
 Any Loss of Vision Burning Styes/Chalazion Cataracts
 Double Vision Tired Eyes Floaters Macular Degeneration
 Other: _____

Personal Eye Information & Social History	Y	N	Please explain
Eye Surgeries/Injury			
Headaches			
Cigarette/Tobacco/Smokeless Tobacco			

FAMILY HISTORY	Y	N	Who in your family has had the following?
Macular Degeneration			
Glaucoma			
Retinal Detachment			
Other Eye Conditions			

I acknowledge receipt of Golden Triangle Optometric Center's Notice of Privacy Practice

X _____ **Date completed** _____