Patient Information Form

Name (legal)_____ Date of Birth:_____

Preferred First Name:_____ Email:_____ _____ Date of last exam:_____

Employer:_____ Occupation:_____

Primary Care Physician:_____ Reason for today's visit:_____

Do you currently wear any of the following? Glasses Contacts None

MEDICAL HISTORY: (please circle yes or no for the following)

Anxiety	Yes | No	Diabetes	Yes | No	Kidney Disease	Yes | No
Arthritis	Yes | No	Heart Disease	Yes | No	Multiple Sclerosis	Yes | No
Asthma	Yes | No	High Cholesterol	Yes | No	Muscle Disease	Yes | No
Cancer	Yes | No	Hypertension	Yes | No	Seizures	Yes | No
Depression	Yes | No	Hyperthyroid	Yes | No	Stroke	Yes | No
Hypothyroid	Yes | No	Other:_____			

EYE HISTORY: Do you experience any of the following? (please circle yes or no)

Blurred Vision	Yes | No	Excess Watering	Yes | No	Itchy Eyes	Yes | No
Burning	Yes | No	Eye Pain/Soreness	Yes | No	Light Flashes	Yes | No
Discharge	Yes | No	Floaters	Yes | No	Light Sensitivity	Yes | No
Dryness	Yes | No	Halos	Yes | No	Redness	Yes | No
Double Vision	Yes | No	Headaches	Yes | No	Sandy/Gritty Feeling	Yes | No

Have you experienced or been treated for any of the following? (please circle and fill in date for those that apply)

Cataract	Yes | No	Currently Have	Treating | Had Surgery	Date of surgery:_____
Glaucoma	Yes | No	Currently Have	Treating | Had Surgery	Date of surgery:_____
Lasik	Yes | No	Currently Have	Treating | Had Surgery	Date of surgery:_____
Lazy Eye	Yes | No	Currently Have	Treating | Had Surgery	Date of surgery:_____
Macular Degeneration	Yes | No	Currently Have	Treating | Had Surgery	Date of surgery:_____
Retinal Detachment	Yes | No	Currently Have	Treating | Had Surgery	Date of surgery:_____

List of prescribed medications:

_____

_____

_____

List of allergies: (including seasonal)

_____

SOCIAL HISTORY (please circle yes or no)

Do you smoke?	Yes | No
Do you vape?	Yes | No
Do you consume alcohol?	Yes | No
Are you pregnant/nursing?	Yes | No

FAMILY MEDICAL HISTORY (please circle yes or no)

Diabetes	Yes | No
Cancer	Yes | No
Cataract	Yes | No
Glaucoma	Yes | No
Macular Degeneration	Yes | No

EYE HEALTH SCREENING TEST

Part of your eye exam may consist of retinal photo imaging. The results of this test can assist in detection of brain tumors, diabetic retinopathy, glaucoma, stroke and other disorders. If this procedure has been performed, we may bill your medical insurance. If the photo is not covered by your medical insurance Fraser Optical will discount the screening to $39 and bill you at a later date. If there is no medical insurance or no reason to bill the medical insurance the $39 will be due on the date of the service.

Please mark one of the following:

_____ Yes, I would like a retinal image taken today _____ No, I do not want an image taken at this time

Consent & Authorization

By signing below, I understand that the information I have provided on this form is accurate to the best of my knowledge. I understand a copy of the office's Notice of Privacy Practices is available upon request.

Name of patient (print)_____ Date_____

Signature of patient or patient representative:_____

Relationship of representative to patient (if patient is a minor or an adult unable to sign this form):_____

OFFICE USE ONLY

Signed Acknowledgement Form Following Prescription Release

As of September 24, 2024, we are required by the Federal Trade Commission to provide patients with a copy of their eyeglass prescription. Please sign below to ackowledge that you were offered a copy of your prescription following your refractive eye examination today.

_____ I was given a copy of my prescription _____ I declined to take my prescription at this time

Consent Form for Electronic Delivery of Prescription

I authorize Fraser Optical to send my eyeglass and/or contact lens prescription to me electronically via email.

_____ Yes _____ No

Email (if yes): _____

Patient Signature: _____ Date:_____