HOEY/SHEM OPTOMETRY
Family Optometry, Pediatrics, Vision Therapy, Contact Lenses
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Welcome to our office! For us to effectively meet your vision and eye health needs, please complete the following:

Patient Information

Legal Last Name _____ First_____ MI _____

Preferred Name _____ Date of Birth_____

Sex assigned at birth _____ Gender _____ (Pronouns _____)

Home Address_____ City_____ Zip_____

Phone #: Home( )_____ Work( )_____ Cell( )_____

Email Address _____

We send out upcoming and annual appointment reminders via text and email.

May we contact you for: Appointments via: (circle all that apply) *home work cell text email*

Occupation (or Grade)_____ Employer (or School)_____

If patient is a minor: Name of Parent/Guardian _____
Your relationship to patient (circle) *Mother Father Other:*
How did you hear about our office _____

Vision and Health Insurance Information

Vision Care Insurance Carrier_____ Member ID#_____

Medical Insurance Carrier_____ Member ID#_____

Member Name:_____Member Date of Birth_____

Do you have Medicare? □ No □ Yes

I attest that the above information is true. I have read and understand the Notice of Privacy Practices of Hoey/Shem Optometry. I understand that I am financially responsible for any balance not covered by my insurance.

_____ _____
Signature Date

Patient Name:_____

Medical/Vision Information

Approximate Date of your last Eye Exam (month/year)_____

Briefly state your chief eye or vision concerns for your visit today _____

Do you experience symptoms like dry, itchy, watery, burning eyes? □ No □ Yes

Do you experience symptoms of headaches, dizziness, neck pain? □ No □ Yes

How many hours do you use a computer or digital device? _____

Do you wear or are interested in contact lenses? □ No □ Yes

Do you wear sunglasses? □ No □ Yes If yes, *Prescription* *Non-Prescription* *Clip-on*

Do you participate in any activities that put your eyes at risk for injury? □ No □ Yes

If yes, do you wear safety glasses? □ No □ Yes

Would you like information on any of the following? (Please check)

□ Computer eyeglasses □ Treatment to reduce or control nearsightedness progression □ Dry Eye Treatments	□ Vision Therapy for learning related visual problems □ Refractive/Laser Eye Surgery to reduce your dependence on glasses/contact lenses

Primary Care Physician Name:_____ Date of Last Physical: _____

Address/Phone:_____

Review of Systems	**No**	**Yes**	**Unknown**		**No**	**Yes**	**Unknown**
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever Weight Loss/Gain	□	□	□	Allergies/Hay Fever	□	□	□
Integumentary (Skin)	□	□	□	Sinus Congestion			
Neurological				Runny Nose	□	□	□
Headaches	□	□	□	Post-Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat/Mouth	□	□	□
Eyes				**Respiratory**			
Loss of vision	□	□	□	Asthma	□	□	□
Blurred Vision	□	□	□	Chronic Bronchitis	□	□	□
Distorted Vision/Halos	□	□	□	Emphysema	□	□	□
Loss of Side Vision	□	□	□	**Vascular / Cardiovascular**			
Double Vision	□	□	□	Diabetes	□	□	□
Dryness	□	□	□	Heart Pain	□	□	□
Mucous Discharge	□	□	□	High Blood Pressure	□	□	□
Redness	□	□	□	Vascular Disease	□	□	□
Sandy or Gritty Feeling	□	□	□	**Gastrointestinal**			
Itching	□	□	□	Diarrhea	□	□	□
Burning	□	□	□	Constipation	□	□	□
Foreign Body Sensation	□	□	□	**Genitourinary**			
Excess Tearing/Watering	□	□	□	Genitals/Kidney/Bladder	□	□	□
Glare/Light Sensitivity	□	□	□	**Bones / Joint / Muscles**			
Eye Pain or Soreness	□	□	□	Rheumatoid Arthritis	□	□	□
Chronic Infection of Eye	□	□	□	Muscle Pain	□	□	□
Frequent Styes	□	□	□	Joint Pain	□	□	□
Flashes/Floaters	□	□	□	**Lymphatic / Hematologic**			
Tired Eyes	□	□	□	Anemia	□	□	□
Endocrine				Bleeding Problems	□	□	□
Thyroid/Other Glands	□	□	□	**Allergic / Immunologic**	□	□	□
				Psychiatric	□	□	□

Patient Name:_____

List any medications you take:

_____

_____

Do you have any allergies to medications? □ No □ Yes If yes, list allergies and the reaction:

_____

Other Allergies (food/environmental):_____

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, retinal disease, cataracts, eye infections, eye injuries:

_____

Are you pregnant or nursing? □ No □ Yes

Social History This information is kept strictly confidential. However, you may discuss this portion direction with the doctor if you prefer.

□ Yes, I would prefer to discuss my Social History information directly with my doctor

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes

If yes, please describe: _____

Do you use tobacco products? □ No □ Yes If yes, type/amount/how long:_____

Do you drink alcohol? □ No □ Yes If yes, type/amount/how long:_____

Do you use illegal drugs? □ No □ Yes If yes, type/amount/how long:_____

Have you been exposed to any sexually transmitted diseases? □ No □ Yes If yes, which _____

Family History Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Disease/Condition	No	Yes	Unknown	Relationship To You
Blindness	□	□	□	_____
Cataracts	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other _____	□	□	□	_____

Patient Signature:_____**Date:**_____