20 | TWENTY
EYECARE

# Patient Checklist

**Please remember to bring the following to your appointment.**

- ☐ **All current eyewear, including your everyday eywear, sunglasses, readers, occupational (computer, specific purpose, etc) or sport glasses.**
- ☐ **Your most recent contact lens prescription or the box/packaging with prescription and brand information. Please note the type of contact lens solution you use.**
- ☐ **A comprehensive list of current medications, both prescription and non-prescription.**
- ☐ **The name and contact information of your primary care provider.**
- ☐ **I.D. cards for your Health Insurance and Vision Insurance Plans.**
- ☐ **20Twenty New Patient Form** (on the next page)

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## Patient Information

Today's Date:____/____/_____
Name: (*last*)_____(*first*)_____(*middle*)_____
Date of Birth:_____ Age:_____ SSN:_____ Sex: ___M_/_F____
Street:_____
City:_____ State:_____ Zip:_____
Cell Phone: _____Home Phone:_____ Work Phone:_____
Email Address: _____ **Preferred contact?: Cell / Home / Work / Email**
Employer (or School) _____ Occupation (or Grade): _____
Marital Status: ☐ Never Married ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated
Race: ☐ American Indian ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native Hawaiian ☐ Other
Please list name of Spouse or BOTH Parents (for minors):_____
Spouse/Parent contact information:_____

## Insurance Information

**-Please note, insurance generally does NOT cover the Contact Lens Evaluation-**

Vision Insurance: _____ Subscriber Name: _____
Subscriber Ins. ID: _____ Subscriber Birth Date: _____
Primary Medical Ins: _____ Subscriber Name: _____
Subscriber Ins. ID: _____ Subscriber Birth Date: _____
Subscriber Address: _____
Subscriber City: _____ State: _____ Zip: _____

**Very Important! New Patients Only**
Who may we thank for referring you to our office? Name of friend or relative:_____
How did you choose our office if not from friend or relative?
☐ Doctor Referral: _____ ☐ Insurance List ☐ Saw Sign/Building
☐ Web Page: _____ ☐ Other: _____

Please tell us why you're here today:_____
Previous Eye Doctor: _____ Date of last exam: _____
Do you currently wear glasses? ___Yes ___No Are you happy with the vision of your glasses? ___Yes ___No
Do you currently wear contact lenses? ___Yes ___No ___Interested in them?
Do you sleep in your contacts? ___Yes (____days/week) ___ No
Brand:_____ Solutions used:_____
Are you satisfied with the vision and comfort of your contact lenses? ___Yes ___No

**Lifestyle Questions: Do you…(check if your answer is yes)**
____Work at a computer?
___ Want information on LASIK or PRK?
___ Have interest in a "test drive" of the latest contact lens?
___ Have family members in need of eyecare?
___ Spend time outdoors? If yes, how many hours per week? _____

**PERSONAL Ocular History** Please check all of the following eye conditions that apply to you:

___ Blurred vision ___ Loss of vision ___ Trouble seeing at night ___ Headaches
___ Sunlight sensitivity ___ Burning ___ Itching ___ Redness
___ Grittiness ___ Dryness ___ Eye Infections ___ Eye Injury
___ Floaters or Spots ___ Flashes of light ___ Lazy Eye/Amblyopia ___ Crossed Eye
___ Cataracts ___ Glaucoma ___ Macular Degeneration
___ LASIK/PRK Surgery ___ Cataract Surgery ___ Retinal Detachment

**PERSONAL Medical History** Please check all of the following medical conditions that apply to you:

__Blood Pressure: __High __Low __Asthma __Arthritis __Respiratory/Lung
__Cholesterol, elevated __Headaches __Migraines __Brain Injury/Concussion
__Diabetes: __Type 1 __ Type 2 __Hypothyroidism __Seizures __Stroke
__Integumentary (skin) __Fatigue __ Unusual weight loss/gain

__Allergies:_____ __Blood/Lymph disorders:_____
__Cancers/tumors:_____ __Neuro-developmental disorders:_____
__Heart/vascular disorders:_____ __Psychiatric disorders:_____
__Kidney disorders:_____ __Liver disorders:_____
__Skin disorders:_____ __Digestive disorders:_____

Have you had any major injuries, hospitalizations or surgeries?_____
Do you currently use cigarette/tobacco products? ___Every day use ___Some day use ___Former use ___No
Do you drink alcohol? ___Yes ___No
Do you use recreational drugs? ___Yes ___No
Are you currently: ___Pregnant (# of weeks____) ___Nursing ___Neither

Do you currently have a primary medical physician? ___Yes ___No
Please list name of physician_____ Date of last check up/physical_____

**List of all your current medications**: *(RX or over the counter, including eye drops, birth control pills, & vitamins)*

| **Medication** | **Use/Reason Prescribed** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Allergies** to medications? _____

**FAMILY Medical History** Please check the conditions that apply to your family. Please specify which family member, and if they are on your mother's/maternal side (M) or father's/paternal side (P)

___ Blindness:_____ ___ Cataracts:_____
___ Macular Degeneration:_____ ___ Glaucoma: _____
___ Retinal Disease:_____ ___ Lazy Eye/Amblyopia:_____
___ Heart Disease:_____ ___ Diabetes:_____
___ Cancers/Tumors:_____ ___ High Blood Pressure:_____
___ Arthritis:_____ ___ Asthma:_____
___ Thyroid Disease: _____ ___ Autoimmune Disorder:_____