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)

Welcome Back to 20 | TWENTY EYECARE

Today's Date:____/____/_____
Name: (*last*)_____(*first*)_____(*middle*)_____
Street:_____
City:_____ State:_____ Zip:_____
Cell Phone: _____Home Phone:_____ Work Phone:_____
Email Address: _____ **Preferred contact?: Cell / Home / Work / Email**
Employer (or School) _____ Occupation (or Grade): _____
Please list name of spouse or BOTH parents (for minors):_____
Spouse/Parent contact information: _____
What is the major purpose of this visit?
_____
_____

Insurance Information

☐ **Insurance is the same as previous visit**
Vision Insurance: _____ Subscriber Name: _____
Subscriber Ins. ID: _____ Subscriber Birth Date: _____
Primary Medical Ins: _____ Subscriber Name: _____
Subscriber Ins. ID: _____ Subscriber Birth Date: _____

Patient Information

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)* _____
_____

Allergies to medications? _____

Since your last visit with us, have you experienced, been diagnosed or treated for any of the following?

__Blood Pressure: __High __Low
__Cholesterol, elevated
__Diabetes: __Type 1 __ Type 2
__Migraines
__Headaches
__Arthritis
__Brain Injury
__Asthma
__Hypothyroidism
__Stroke
__Cancer
__Fatigue
__Psychological
__Floaters or Spots
__Flashes of light
__Dryness
__Trouble seeing at night
__Eye Injury
__Eye Infections
__Cataracts/surgery
__LASIK/PRK surgery
__Retinal Detachment
__Mac. Degeneration
__Glaucoma
__Loss of Vision