CORNELL EYECARE

DR. CHAD W. LAWSON

RETURN Patient Information (All information will be Confidential)

Patient _____ Today's Date _____ Date of Birth _____

Address _____ City/State/Zip _____

Phone: Home _____ Work _____ E-mail address _____

Reason for today's visit ☐ Reminder Card/Postcard ☐ Glasses ☐ Contacts ☐Other_____

Insurance Information **VISION** **MEDICAL**

S. S. # _____ Insurance Co. Name _____

Name of insurance co._____ Name of insured _____

ID/Policy#_____ ID/Policy# _____

Group# _____ Group #_____

DO YOU HAVE ADDITIONAL INSURANCE WE SHOULD BILL? ☐ **yes** ☐ **no**

Visual Information

Please check all that you are experiencing with your current correction: ☐ **No change**

Yes	Yes	Yes	Yes
☐ Blur far away	☐ Eyes itch	☐ Discharge from eyes	☐ Reading held at 10" or less
☐ Blur up close	☐ Eyes water easily	☐ Light sensitivity	☐ Double vision
☐ Headaches	☐ Dry eyes	☐ Pain in or around eyes	☐ Eyes burn
☐ Squinting	☐ Floaters or spots	☐ Eye strain/tired eyes	☐ Night vision problems

Have you had any eye injury, infection or surgery? ☐ yes ☐ no Explain _____

Lifestyle Factors! Your answers will assist us in selecting the best eyewear for you!

Occupation _____ Spouses' Occupation _____

Are you required to wear safety glasses at work? ☐ yes ☐ no

Do you work at a computer or video display terminal? ☐ yes ☐ no

Are you tired of wearing glasses and interested in contacts? ☐ yes ☐ no

Do you have a back-up pair of glasses available? ☐ yes ☐ no

Do you have prescription sunglasses? ☐ yes ☐ no

Hobbies_____

Do you use any of the following on a regular basis: _____Tobacco _____Alcohol _____Other Substances

Contact Lens Wearers

Please initial that you have read and understand the contact lens fitting fees listed in our Contact Lens Information Sheet provided on this clipboard. _____

Health Information

Please list any **NEW** medications you are taking and their purpose: _____

Have you had any **NEW** changes in your health or any major health problems? ☐ yes ☐ no ☐ **No change**

Do you or does anyone in your family have a history of:

Self	Family		Self	Family		Self	Family	
☐	☐	High Blood Pressure	☐	☐	Arthritis	☐	☐	Amblyopia (lazy eye)
☐	☐	Heart Disease	☐	☐	Epilepsy	☐	☐	Eye Disease
☐	☐	Stroke	☐	☐	Cancer	☐	☐	Cataract
☐	☐	Diabetes	☐	☐	Hypoglycemia	☐	☐	Allergies/Hay Fever
☐	☐	Thyroid Problems	☐	☐	Glaucoma	☐	☐	Strabismus (crossed or wall eyes)

Are you allergic to any medications? ☐ yes ☐ no Please list _____

Authorization - I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

X _____

Signature of Patient (Or parent if a minor) Date Doctor Initials/Date