HERCULES
OPTOMETRIC GROUP

WELCOME TO OUR OFFICE!

NAME (Last)________________________ (First)__________________________ MI ______
EMAIL____________________________________ Cell Phone____________________________

VISION Insurance_______________ MEDICAL Insurance_______________________________

Address____
Home Phone______________________________ Work Phone___________________________
Date of Birth______________________ Guardian (if under 18)__________________________
Occupation_______________________Emergency Contact______________________________
Last Eye Exam____________________ Primary Care Physician___________________________

HEALTH INFORMATION

What is the reason for today's visit?____

Vision complaints? ☐ Distance blur ☐ Reading blur ☐ Eyestrain ☐ Computer strain/fatigue
☐ Night glare ☐ Other:____

Do you have: ☐ Diabetes ☐ Hypertension (High Blood Pressure) ☐ High Cholesterol

Please check if you have any problems with the following body systems:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Gastrointestinal	☐	☐	Ears, Nose, Throat	☐	☐	Cardiovascular	☐	☐	Neurological
☐	☐	Respiratory	☐	☐	Lymphatic / Blood	☐	☐	Endocrine	☐	☐	Eyes
☐	☐	Genitourinary	☐	☐	Musculoskeletal	☐	☐	Skin	☐	☐	Mental

If YES to any above, please explain: ____
____

Current Medications:____
Medication Allergies:____
Do you use (Freq. & amount): ☐ Tobacco___________ ☐ Alcohol_________ ☐ Drugs_________
Recent Injuries, Surgeries, Hospitalization:____

EYE HISTORY

Previous eye trauma, surgery, infection?____
☐ Blurred vision ☐ Dry Eyes ☐ Stye ☐ Strabismus (eye turn) ☐ Amblyopia (lazy eye)
☐ Cataract ☐ Glaucoma ☐ Retinal hole/tear/detachment ☐ Macular Degeneration
☐ Eye allergy ☐ Conjunctivitis (pink eye) ☐ Other:_______________________________
Do you wear: ☐ Glasses ☐ Contacts (type):____________________________________

FAMILY HISTORY

Please note anyone in your family with a history of the following conditions:

☐ Diabetes_____________________________ ☐ Hypertension__________________________
☐ Heart Disease_______________________ ☐ Cancer ____________________________
☐ High Cholesterol_______________________ ☐ Autoimmune__________________________
☐ Cataract ____________________________ ☐ Glaucoma ___________________________
☐ Macular Degeneration___________________ ☐ Retinal disease_________________________
☐ Strabismus__________________________ ☐ Amblyopia___________________________
☐ Other:____

I hereby authorize the release of any medical information necessary to notify my family physician and/or process an insurance claim. I understand I am responsible for any charges not covered by my insurance.

Signature____ Date____________________

HOW DID YOU FIND US?____