

Welcome to Prather Family Eyecare

Today's Date: ____/____/____

Patient Name: _____ DOB: ____/____/____ Primary Phone Number: (____) ____ - ____

Home Address: _____ City, State, Zip: _____

Email: _____ Occupation/Employer: _____

How did you find Prather Family Eyecare? _____

Insurance Information

Who is the main holder of insurance? (Circle one of the following) Self / Spouse / Parent or Guardian

*If you circle anything other than "Self" please fill out the information below.

Name: _____ DOB: ____/____/____ Social Security Number: ____ - ____ - ____

Visual History

Reason for today's visit: _____

Date of last exam: ____/____/____ Location/Doctor: _____

Do you use a computer/cell phone daily? Yes or No If "Yes" how many hours a day? _____

What type of protection do you currently use against harmful UV and Blue Light? _____

What are your hobbies/activities outside of work or school? _____

Current Contact Lens Wearers

How often do you *remove* your contacts? Daily / Other *If other please specify _____

How often do you *change* your contacts? Daily / Bi-Weekly / Monthly/Other _____

What type/brand of Contacts do you currently wear? _____

Personal and Family Health History

Primary care physician: _____ Pharmacy: _____

Type 1 or 2 Diabetic: Yes or No Self/ Please specify family member(s) _____

Hypertension: Yes or No Self/ Please specify family member(s) _____

Thyroid Disease: Yes or No Self/ Please specify family member(s) _____

History of stroke: Yes or No Self/ Please specify family member(s) _____

Auto immune/Genetic Disease: Yes or No Self/ Please specify family member(s) _____

Cataracts: Yes or No Self/ Please specify family member(s) _____

Glaucoma: Yes or No Self/ Please specify family member(s) _____

Macular Degeneration: Yes or No Self/ Please specify family member(s) _____

Please note any past eye injuries, surgeries, or diseases? _____

Current Medication(s)/Eye drops: _____

Allergies: _____