

# Dr. J. Jeffrey Hughes

*Welcome To Our Office!*

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Single - M - W - D

E- Mail \_\_\_\_\_ @ \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Cell Phone ( ) \_\_\_\_\_

Employer/School \_\_\_\_\_ Grade \_\_\_\_\_

Social Security # \_\_\_\_\_

Family Doctor \_\_\_\_\_

Has anyone in your household ever been a patient of ours?

If so, who? \_\_\_\_\_

Who recommended our office to you? \_\_\_\_\_

Do you have vision insurance?  yes  no

Name of Insurance Company \_\_\_\_\_

Are you interested in laser correction? \_\_\_\_\_

Payment is requested when services are rendered.

Method of Payment:  Cash  Check  Bank Card  Insurance

OVER

## Health History

Reason for today's exam \_\_\_\_\_

Date of last exam \_\_\_\_\_ Name of eye doctor \_\_\_\_\_

Do you have a history of the following?

- Diabetes       Blindness       High blood pressure
- Cataracts       Turned or lazy eye       Glaucoma
- Heart condition       Frequent headaches
- Pregnant       Drug Allergies       Allergies
- Sinus trouble       Have given birth in last 6mo.

Please list all medications and vitamins you are currently taking:

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Have you ever had any of the following conditions involving your eyes?

- Eye surgery       Sensitivity to light       Eye infection or disease
- Eye injury       Floaters or spots       Double vision
- Medical treatment       Poor distance vision       Eye strain
- Severe pain       Poor near vision       Eyes burn, itch, or water

Do you wear glasses?     Yes     No

Have you ever worn contacts?     Yes     No

Are you interested in wearing contact lenses?     Yes     No

Do you work at a computer?     Yes     No

What hobbies or sports do you participate in? \_\_\_\_\_

*Thanks for choosing our office.*