WELCOME TO DR. BLOCH'S OFFICE

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

TELEPHONE (HM)_____(WK)_____

OCCUPATION_____

EMPLOYER_____

AGE_____

BIRTH DATE_____

SEX MALE FEMALE

SS #_____

SCHOOL_____

E-MAIL_____

REFERRED BY:

- ❑ FAMILY
- ❑ FRIEND
- ❑ DOCTOR
- ❑ SCHOOL
- ❑ YELLOW PAGES
- ❑ ADVERTISEMENT
- ❑ INSURANCE DIRECTORY
- ❑ INTERNET
- ❑ OTHER_____

REASON FOR VISIT

- ❑ FIRST EXAM
- ❑ CHECK UP / UPDATE RX
- ❑ WANTS CONTACT LENSES
- ❑ SCHOOL REFERRED
- ❑ DOCTOR REFERRED
- ❑ DRIVER'S LICENSE
- ❑ JOB REQUIREMENT

- ❑ HEADACHE
- ❑ EYESTRAIN
- ❑ TIRED EYES
- ❑ DELAYED FOCUSING
- ❑ EXCESSIVE BLINKING
- ❑ EYELID(S) TWITCH
- ❑ SQUINTING

- ❑ EYE INJURY
- ❑ EYE PAIN
- ❑ RED EYE(S)
- ❑ DRY EYE(S)
- ❑ EYE(S) ITCH
- ❑ EYE(S) TEAR
- ❑ EYE(S) BURN / STING
- ❑ LIGHT SENSITVITY
- ❑ LIDS/LASHES CRUSTING
- ❑ EYE(S) DISCHARGE
- ❑ BUMP ON EYE OR EYELID

- ❑ SEEING FLASHES
- ❑ SEEING FLOATERS
- ❑ SEEING SPOTS
- ❑ VISION MISSING
- ❑ VISION COVERED
- ❑ COLORS ALTERED

- ❑ DISTANCE VISION POOR
- ❑ NEAR VISION POOR
- ❑ MID-RANGE VISION POOR
- ❑ NIGHT VISION POOR
- ❑ GLARE

- ❑ GHOST IMAGE
- ❑ DOUBLE VISION
- ❑ TURNED EYE(S)
- ❑ LOSES PLACE WHEN READING

OTHER (PLEASE DESCRIBE)

_____

_____

LAST EYE EXAM_____

LAST DILATION_____

HEALTH HISTORY

self	family		self	family		self	family		self	family	
❑	❑	NO HEALTH PROBLEMS	❑	❑	DIABETES	❑	❑	LIVER PROBLEMS	❑	❑	WEAR VISION CORRECTION
❑	❑	ALLERGIES	❑	❑	HIGH BLOOD PRESSURE	❑	❑	KIDNEY PROBLEMS	❑	❑	CATARACTS
❑	❑	ASTHMA	❑	❑	HEART PROBLEMS	❑	❑	DIGESTIVE PROBLEMS	❑	❑	GLAUCOMA
❑	❑	SINUS	❑	❑	LUNG PROBLEMS	❑	❑	SKIN CONDITIONS	❑	❑	RETINAL DISEASE
❑	❑	HEADACHES/MIGRAINES	❑	❑	THYROID PROBLEMS	❑	❑	OTHER_____	❑	❑	VISION LOSS
			❑	❑	CANCER				❑	❑	COLOR VISION PROBLEMS
									❑	❑	LAZY OR TURNED EYE

LIST ANY MEDICATIONS YOU ARE TAKING_____

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO_____

YOUR PHYSICIAN'S NAME AND TELEPHONE_____

WOMEN ONLY: ARE YOU PREGNANT? YES OR NO

CONTACT LENS HISTORY

- ❑ DOES NOT USE CONTACTS
- ❑ USES SOFT CONTACTS
- ❑ USES GAS PERMEABLE CONTACTS
- ❑ USES COLORED CONTACTS
- ❑ USES CONVENTIONAL CONTACTS
- ❑ USES DISPOSABLE CONTACTS

- ❑ CONTACTS NOT CLEAR ENOUGH
- ❑ CONTACTS CAUSE REDNESS
- ❑ CONTACTS CAUSE DISCOMFORT
- ❑ CONTACTS CAUSE DRYNESS
- ❑ CONTACTS DO NOT FIT WELL
- ❑ OTHER_____

HAS BEEN USING CONTACTS _____YRS

SLEEPS IN CONTACTS YES OR NO

NAME OF CARE PRODUCT_____

AUTHORIZATION FOR TREATMENT

SIGNATURE OF PATIENT_____DATE_____