

WELCOME TO OUR OFFICE!
Mark D. Noss O.D. and Rebekah Noss Lynch O.D.
 We appreciate you taking the time to complete this important form.

PATIENT INFORMATION

Today's Date: _____	SS#: _____
Last Name: _____	First Name: _____ MI: _____
Preferred Name: _____	Date of Birth: ____ / ____ / ____ Age: _____
Address: _____	Email Address: _____
City: _____ State/Zip: _____	Home Phone: (____) _____
Day/Work Phone: (____) _____	Cell Phone: (____) _____

Employed Not Employed Student Retired
 Full Time Part Time
 Employer: _____
 Occupation: _____
 Ethnicity/Race: White/Caucasian Asian
 Black/African American Hispanic/Latino
 American Indian/Alaskan Native Other
 Native Hawaiian/Pacific Islander
 Preferred Language: English Spanish Other

Our office uses phone, email and text to remind you of appointments and to alert you when your glasses or contact lenses are ready to dispense.

May we contact you by: Phone Text Mail Email
 Preferred contact number: Home Cell Work
 How did you hear about us? Family Friend Doctor
 Insurance Company Internet School Phonebook

Whom may we thank for the referral?

Marital Status: Single Married Divorced Widowed

Spouse's Name: _____

GUARDIAN/GUARANTOR INFORMATION (if applicable)

Guardian//Parent: _____	Relationship: _____
Address: _____	Date of Birth: ____ / ____ / ____ SS#: _____
City: _____ State/Zip: _____	Phone: (____) _____

PERSONAL EYE HISTORY

Date of last eye exam? _____ Place/Doctor: _____

Do you wear glasses? Yes No If yes, how old are they? _____

Do you wear contact lenses? Yes No If yes, what brand? _____

Are you interested in contact lenses today? Yes No

Please be sure to present our office with ALL current insurance cards.
 Payment is expected when services are rendered.
 Please complete both sides of this form.

Thank You ☺

Please be sure you have completed both sides of this form!

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Hobbies

Indoor _____ Outdoor _____

Computer Use: 1-2 hours 3-4hours 6-8 hours

Does any of the following bother you: Computer Screens Sun Oncoming Traffic

Personal Medical History Name of your medical doctor _____ Date of last physical _____

List all medications you are currently taking (prescription and over the counter) _____

Do you have any allergies to medications? Yes No If yes, please explain _____

Please list any MAJOR illnesses, injuries, or eye surgeries you have had _____

Are you pregnant or nursing? Yes No

Social History

Do you engage in regular exercise? Yes No Do you use illegal drugs? Yes No

Do you drink alcohol? Yes No If Yes, how much/often Occasional 1-2/day 3-4/day Alcohol Dependence

Do you use tobacco? Yes No If Yes, how much/often Occasional 1/2 pack/day 1 pack/day 1+ pack/day

Method of Tobacco Intake: Smoking Chewing

Review of Systems Are you experiencing any of the following?

OCULAR

	Yes	No	Explain		Yes	No	Explain
Blurred Vision				Eye Injury			
Loss of Vision				Amblyopia (lazy eye)			
Tired Eyes				Macular Degeneration			
Glare				Glaucoma			
Excessive Tears				Cataracts			
Sandy or Dry Eyes				Diabetic Retinopathy			
Redness				Floater			
Autoimmune Disease				Skin Disorders			
Cardiovascular (heart disease, high blood pressure, high cholesterol)				Neurological (headaches, MS, seizures)			
Ears/Nose/Throat				Cancer			
Diabetes, Thyroid				Gastrointestinal			
Bone, Muscle, Joints (arthritis)				Blood/Lymph (anemia)			
Allergic/Immunologic (seasonal allergies)				Genitourinary (kidneys, bladder)			
Respiratory (asthma/emphysema)				Psychiatric (anxiety, depression)			

MEDICAL

Family Medical History Please note any family members with the following medical condition:

**For Relationship - please note paternal (P) or maternal (M)*

Condition	Yes	No	Relationship*	Condition	Yes	No	Relationship*
Diabetes				High Blood Pressure			
Blindness				Heart Disease			
Glaucoma				Macular Degeneration			