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** □ **½ pack/day** □ **1 pack/day** □ **1+ pack/day**

Method of Tobacco Intake: □ **Smoking** □ **Chewing**

Review of Systems Are you experiencing any of the following?

	Yes	No	Explain		Yes	No	Explain
OCULAR							
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				Floaters			
MEDICAL							
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)			

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			