BOGEY HILLS
VISION CENTER
Professional Care Your Eyes Deserve

Welcome To Our Office

Dr. Alan Kwiatek Dr. M. Jean Bennett Dr. Rachel Merriman

Patient's Name _____ Date of Birth _____ Age _____

Phone Number _____ Spouse or Parent Name _____

Occupation _____ Employer Name _____

Insured's ID # _____ Responsible Party ☐Self or _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Reason for today's visit:

☐ Eye Health and Vision Exam
☐ New Eyeglasses; Do you want to look at new frames? ☐Yes ☐No
☐ Contact Lenses; Please explain any problems _____
☐ Interested in lasik
☐ Eye/Vision problem, Please explain _____

Medical History

	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
Gastrointestinal	☐	☐	Urinary	☐	☐	Allergies	☐	☐
Ear/Nose/Throat	☐	☐	Skin	☐	☐	Immune Disease	☐	☐
Cardiovascular (Heart)	☐	☐	Blood/Lymph	☐	☐	Cancer	☐	☐
Respiratory	☐	☐	Endocrine (Glands)	☐	☐	Cholesterol	☐	☐
Headaches	☐	☐	Psychiatric	☐	☐	Arthritis	☐	☐
Nervous System	☐	☐	Diabetes	☐	☐	Other _____	☐	☐
Musculoskeletal	☐	☐	High Blood Pressure	☐	☐			

Major Surgeries (what & when) _____

Eye Health History

	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
Dry Eyes	☐	☐	Glaucoma	☐	☐	Eye Infections	☐	☐
Blurred Vision	☐	☐	Cataracts	☐	☐	Wear Glasses	☐	☐
Retinal Detach/Disease	☐	☐	Eye Surgeries	☐	☐	Wear Contact Lenses	☐	☐
Macular Degeneration	☐	☐	Eye Injuries	☐	☐	Other _____	☐	☐

Are you currently pregnant or nursing? ☐ Yes ☐ No
Are you in good general health? ☐ Yes ☐ No
Do you take medications? ☐ Yes ☐ No Please list names and how often: _____
_____

Have you ever had any ALLERGIC reactions to medications or other substances? ☐ Yes ☐ No
If yes, please list names _____

Name of primary care physician _____ Date of last physical _____

Do you smoke? ☐ Yes ☐ No How much? _____
Do you drink alcohol? ☐ Yes ☐ No How much? _____
Do you use other substances or illegal drugs? ☐ Yes ☐ No

Whom may we thank for referring you to our office today? _____

Signature _____ Date _____
(Parent or guardian if under 18) (Relationship to patient)