WELCOME TO OUR OFFICE

W. LEE MACKEWIZ, O.D., P.A.

BEAR EYE ASSOCIATES

PLEASE PRINT **DATE:** .

NAME (Last, First, Middle)	**BIRTHDATE** (Age)	**SEX** M F	**INSURANCE**
ADDRESS	**RELATIONSHIP TO INSURED (**circle) self spouse child other		**INSURED'S ID#**
CITY **STATE**	**STATUS** (circle) single married other		**OTHER INSURANCE**
ZIP CODE **TELEPHONE** ( )	employed full-time student part-time student		(have your card copy for our file)
IS CONDITION RELATED TO: EMPLOYMENT? yes _____ no _____ **AUTO ACCIDENT?** yes _____ no _____ **PLACE** (State) _____ **OTHER ACCIDENT?** yes _____ no _____			
PLACE OF EMPLOYMENT (Address)	**OCCUPATION**		**WORK PHONE #** ( )
RESPONSIBLE PARTY AND ADDRESS (if different)			

Have you ever worn glasses? Yes _____ No __ How are they used? Distance _____ Near _____ Constantly _____
Have you ever worn contact lenses? Yes _____ No _____ Type _____
Disinfection System_____ How old are your current lenses? _____
Approximate date of your last exam? _____ Previous Eye Doctor _____
Recommended by? _____

Your reasons for visiting our office today: (Please check appropriate items)

_____ General Check-up (no specific problem)
_____ Lost or broke glasses
_____ Want new glasses
_____ Blurred distance vision
_____ Blurred intermediate vision
_____ Blurred near vision
_____ Double vision
_____ Headaches - when do you get them and how often?_____
_____ Eyes water
_____ Glare
_____ Eyes burn
_____ Eyes itch
_____ Eyes feel dry
_____ Pain in eyes
_____ See "spots"
_____ See "light flashes"
_____ Foreign body sensation (something in your eye)
_____ Want contact lenses
_____ Soft _____ Extended wear
_____ Gas permeable
_____ Disposable
_____Bifocal contact lenses
_____ Contact lens check-up
_____ Problems with present contacts
_____ Laser Vision Correction
_____Other (please list) _____

Hobbies _____ _____

Your general health and ocular health (past or present): (Please check appropriate items)

_____ High blood pressure
_____ Diabetes
_____ Allergies
_____ Cancer
_____ Arthritis
_____ Respiratory problems
_____ Circulatory problems
_____ Multiple sclerosis
_____ Other (please list)
_____
_____
_____
_____ Blindness
_____ Cataracts
_____ "Crossed eyes"
_____ "Lazy eye"
_____ Glaucoma
_____ Amblyopia
_____ Retinal disorders
_____ Eye injuries
_____ Eye surgery When? _____
_____ Other (please list)
_____
_____

Are you PREGNANT? Yes _____ No _____
Has anyone in your family (blood related) had any of the above conditions? Yes _____ No _____
If so, what relative and what condition(s)? (Please list here, do not check above) _____
_____
If you are presently taking any medications, hormones or birth control pills? (Please list) _____
_____
Are you allergic to any medication or eye drops? (Please list) _____
Have your eyes been dilated before Yes _____ No _____ If so, when? _____
Your Family Doctor (name) _____

Thank you for the privilege of allowing us to be of service to you.