Hutto Vision Care
...Come see the difference!

Welcome to our office!

Last name:_____ **First Name**:_____ **Middle Initial**_____

Title: Mr. Mrs. Miss Dr. Ms. Master **Nickname**:_____ **Height** _____ft_____in **Weight** _____lbs

Address:_____

City:_____ **State**:_____ **Zip**:_____

Phone numbers: Daytime_____

Cell_____

Other_____

E-mail Address(no 3rd party solicitations):_____

Date of Birth:_____ **Social Security #**:_____

Marital Status: Single Married Divorced Widow(er) **Employment**: Full Part-time Disability Unemployed

Occupation:_____

How did you hear about us? Insurance Friend/Family Advertisement Drive-by Internet Other:_____

Referral name:_____

Preferred language: English Spanish Other_____

Race: White African American Hispanic Asian American Indian **Ethnicity**: Hispanic Pacific Islander Other

Preferred communication method: Phone E-mail Postal mail **Is texting you permissible?** Yes No

What brings you in today? Glasses Contacts Infection Trauma

Other:_____

Do you wear contacts? Yes No

What brand of contacts do you currently wear? _____

Are you happy with your contacts? Yes No **If not, please circle or list why:** Dryness Irritation Pain

Other:_____

_____

Do you prioritize your contacts based on : Comfort Cost Overnight wear capable Health

Other: _____

_____

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Please list any drug allergies: _____

Your current medications: _____

Do you use tobacco? YES NO **If yes, type/amount/howlong** _____

Have you ever used tobacco? YES NO **If yes, how long ago did you quit?** _____

Do you drink alcohol? YES NO **If yes, type/amount/howlong** _____

Do you use illegal drugs? YES NO **If yes, type/amount/howlong** _____

Are you pregnant? YES NO **If not, is there any possibility of pregnancy?** YES NO

Your hobbies and special visual needs? _____

Personal Health History: Please circle applicable conditions that apply to you.

Allergic/ImmunologicNeg	**Ears, Nose, Mouth Neg & Throat**	**Gastrointestinal Neg**	**Integumentary Neg**	**Psychiatric Neg**
environmental allergy		crohn's	eczema	depression
rheumatoid arthritis		colitis	rosacea	panic disorder
lupus	upper respiratory infec.	ulcer	psoriasis	schizophrenia
		digestive		dementia
Cardiovascular Neg	**Endocrine Neg**	**Genitourinary Neg**	**Musculoskeletal Neg**	**Respiratory Neg**
heart disease	non-insulin dependent diabetes	STD – herpetic, Chlamydial	fibromyalgia	cigarette smoker
hypertension	insulin-depend diabetes	kidney or bladder disorders	muscular dystrophy	asthma
stroke	thyroid dysfunction		osteoarthritis	bronchitis
vascular disease	hormonal dysfunction		ankylosing spondylitis	emphysema
			osteoporosis	COPD
Constitutional Neg	**Eyes Neg**	**Hematologic/Lymphatic Neg**	**Neurological Neg**	**Cancer Neg**
developmental disability	glaucoma	anemia	multiple sclerosis	specify type:
weight loss	cataracts	large volume blood loss	epilepsy	
fever	macular degeneration	leukemia		When diagnosed:
fatigue	surgery			
trauma	inflammatory disorders			

Family History: M=Mother F=Father S=Sister B=Brother PGM=Paternal Grandmother PGF=Paternal grandfather MGM=Maternal Grandmother MGF=Maternal Grandfather

Cataracts: M F S B MGM MGF PGM PGF **Strabismus**: M F S B MGM MGF PGM PGF

Glaucoma: M F S B MGM MGF PGM PGF **Macular Degeneration**: M F S B MGM MGF PGM PGF

Depression: M F S B MGM MGF PGM PGF **Heart Disease**: M F S B MGM MGF PGM PGF

Hypertension: M F S B MGM MGF PGM PGF **Stroke**: M F S B MGM MGF PGM PGF

Diabetes: M F S B MGM MGF PGM PGF **Thyroid Dysfunction**: M F S B MGM MGF PGM PGF

Hormonal Dysfunction: M F S B MGM MGF PGM PGF

Autoimmune disease: M F S B MGM MGF PGM PGF