ARNOLD M. STOKOL, O.D.
and Associates

**WELCOME**

Last Name: _____ Date: _____

First Name: _____ M.I. _____ Email Address: _____

Mr./Mrs./Ms./Dr. _____ Birth Date: _____ Social Security #: _____

Preferred First Name: _____ Employer: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____ Marital Status _____

Home Phone: ( ) _____ Spouse's Name: _____

Work Phone: ( ) _____ Driver's License #: _____

Mobile Phone: ( ) _____ Medicare # _____

Preferred Contact Number: ☐ Home ☐ Work ☐ Mobile

Who may we thank for referring you to our office? _____

Family members who are now our patients: _____

Recreation & Hobbies _____

Payment* Method: ☐ Check ☐ Cash ☐ Credit Card

*A Service Fee will be added to returned checks, as well as for any balance that is turned over for collection.

*Our Office does not file insurance, other than Government Medicare.

Our office complies with HIPAA.

You may have a copy of the Notice of Privacy Practice that is posted in the office.

☐ I want a copy ☐ I do not want a copy

Your spectacles are not safety glasses. They are dress eyewear and are not intended for yard work, home chores, or industrial/sports usage. Separate safety spectacles are advised for such activities.

_____ _____

Signature (or Guardian's) Date

Patient Name: _____ Date: _____

**History**

***All information received is kept strictly confidential.***

What is the main reason for your visit? _____

Do you wear glasses? _____ Age of current pair: _____ Do you want new glasses? _____

Do you wear contact lenses? _____ Type of contact lenses: _____

Age of current pair: _____ Contact lens solution: _____

Are you interested in Lasik surgery? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

How many hours a day are you on a computer? _____

Do you have headaches? ☐ Yes ☐ No How often? _____

Describe your headaches: _____

Family eye health problems:(such as glaucoma): _____

Approx. date of last full eye exam: _____ Doctor: _____ City: _____ State: _____

**Check if you have:**

| | | | |
|---|---|---|---|
| ☐ Blurred vision at distance | ☐ Double Vision | ☐ Sandy or gritty feeling | ☐ Mucous discharge |
| ☐ Blurred vision at near | ☐ Floaters/Spots in Vision | ☐ Redness | ☐ Tearing |
| ☐ Blurred vision at intermediate | ☐ Flashes | ☐ Dry Eyes | ☐ Eyelid problem |
| ☐ Tired eyes | ☐ Light Sensitivity | ☐ Burning | ☐ Other |
| ☐ Loss of Vision | ☐ Eye Pain | ☐ Itching | |

**Have you ever had:**

| | | | |
|---|---|---|---|
| ☐ Glaucoma | ☐ Macular Degeneration | ☐ Blindness | ☐ Lazy eye |
| ☐ Cataracts | ☐ Retinal disease | ☐ Poor color vision | ☐ Crossed eye |

☐ Eye Surgery – what type? _____ When? _____

☐ Serious eye injury – what type? _____ When? _____

**Check if you have:**

| | | |
|---|---|---|
| ☐ Allergies | ☐ Thyroid Problems | ☐ Multiple Sclerosis |
| ☐ Unexplained weight change | ☐ Asthma | ☐ Depression/Anxiety |
| ☐ Heart/Vascular Disease | ☐ Emphysema/COPD | ☐ Arthritis |
| ☐ High Blood Pressure | ☐ Cancer | ☐ HIV |
| ☐ Muscle/Joint Pain | ☐ Migraines | ☐ Anemia/Sickle Cell |
| ☐ Diabetes | ☐ Seizures | ☐ Dry Mouth |

What is your current weight? _____ What is your height? _____

Patient Name: _____ Date: _____

**Social History**

☐ Yes, I would prefer to discuss this portion directly with the doctor.

☐ I choose not to discuss my social history

Do you drive? ☐ Yes ☐ No If yes, do you have difficulty driving? _____

Do you use tobacco or smoke? ☐ Yes ☐ No If yes, amount/how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, amount? _____

**List any medications you are taking (including hormones, birth control, vitamins, etc.):**

**List any medications you are allergic to:**

**Check if there is a family history of:**

☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Thyroid Disease

☐ High Blood Pressure ☐ Arthritis ☐ Lung Disease