Murray Vision Source

Welcome to our office! Help us get to know you better by completing the following information:

Patient's Legal Name: _____ Today's Date: _____

Preferred/Nick Name: _____ SS#: _____ Date of Birth: _____

Mailing Address: _____City: _____ State: _____ Zip: _____

Cell Phone #: _____ Home #:_____

Email Address: _____ **Preferred Pharmacy**: _____

Circle answers to the following: Sex: M / F **Race**: White / Black / Hispanic / Prefer Not To Respond / Other:_____

Do you smoke? Never Yes Quit (Year quit:_____) If yes: How many packs per day?_____ How many years?_____

Do you use smokeless tobacco or E-cigarettes/vaping? Never Occasionally Frequently

Do you drink alcohol? Never Socially 1-2 per day More than 2 per day

Have you had a sexually transmitted disease? If yes, circle: HIV Syphilis Gonorrhea Other: _____

Have you had a blood transfusion? No Yes If yes, approx. date: _____

Employer: _____ Occupation: _____

Or if Student, School Attending: _____ Grade: _____

Name of Family Physician: _____ Phone #: _____

If patient is a minor, please list the person that has legal authority to make medical/financial decisions for the patient:

Parent or Guardian's Name: _____ Contact # _____

Please list **medications** with dosage (including herbal supplements) you take every day or circle **NONE**:

_____

_____

List any **medications you are allergic** to or circle **NONE**: _____

List any **surgeries** with approximate dates if known or circle **NONE**:

_____

_____

Have you ever been diagnosed or treated for any of the following? Circle any that apply or circle NONE:

Environmental Allergy / Asthma / Arthritis / Cancer / Cholesterol / Thyroid Disease / Kidney Disease / Osteoporosis

Fibromyalgia / Stroke / Multiple Sclerosis / Epilepsy / Ulcer / Depression / Schizophrenia / Bronchitis / Emphysema

Extreme Weight loss or gain /Leukemia / Crohn's Disease / Skin Disease / Heart Disease

Are you a diabetic? **No** **Yes** If yes, for how many years? _____ Last A1C? _____

Do you have High Blood Pressure? **No** **Yes** If yes, for how many years? _____

Any other disorders not listed: _____

**NEW PATIENTS CONTINUE. RETURNING PATIENTS ONLY IF INFO CHANGED:

Approx. date of last eye exam: _____ By whom:_____ Do you wear glasses? _____

Contact Lens Info - Brand: _____ Power if known: Right_____/Left_____

Have you ever been diagnosed or treated for any of the following eye disorders? Circle any that apply or NONE:

Cataracts / Glaucoma / Corneal Abrasion / Eye Infection / Lazy Eye / Crossed Eye / Iritis / Retinal Detachment

Double Vision / Macular Degeneration / Tearing / Sunlight Sensitivity / Itchiness / Grittiness / Trouble seeing at night

Eye Injury / Floaters / Flashes of light / Eye Dryness

Other eye disorders not listed: _____

Approx Date(s) of Cataract Surgery: _____ Name of Surgeon: _____

FAMILY Medical/Eye History:

List Relationship:		List Relationship:	
Diabetes:	_____	**Macular Degeneration:**	_____
Heart Disease:	_____	**Retinal Problems:**	_____
Blindness:	_____	**Corneal Problems:**	_____
Cataracts:	_____	**Lazy Eye:**	_____
Glaucoma:	_____	**Other:**	_____

Insurance Information:

Name of Vision Insurance: _____ Contract/Member ID #: _____

Name of Medical Insurance: _____Contract/Member ID #:_____

Name of Secondary Medical Insurance: _____Contract/Member ID #:_____

Name of Subscriber if not patient: _____ DOB of Subscriber: _____

*****For many Vision Insurance plans, as well as Tricare for medical, the contract # will be the member's SS#*****

PATIENT SIGNATURE (OR LEGAL GUARDIAN FOR MINOR): _____ Date: _____