Kimberly McLeod, OD *S. Gary Mizerak, OD*

WELCOME TO
McLeod Eye Associates, P.C.

NAME____ DOB_____/_____/________ DATE_______________

ADDRESS (Residential/Mailing)____AGE____________

CITY___________________________ STATE________ ZIP____________ OCCUPATION _____________________

PRIMARY PHONE(Hm/Wk/Cell) (______)__________________ ALT. PHONE(Hm/Wk/Cell) (______)___________________

EMAIL ADDRESS____

~GENERAL INFORMATION~

Do you wear glasses for: DISTANCE; READING; BOTH; NONE (PLEASE **CIRCLE**)

What is the reason for your visit today?____

When was your last **EYE** exam if elsewhere?_________Doctor's Name_________________________

Have you had any of the following eye problems? (**CHECK** all that apply)

_____Pain _____Glaucoma _____Infections _____Headaches

_____Redness _____Cataracts _____Flashes of Light _____Blurry Vision

_____Eye Turn _____Injury _____Floating Spots _____Other__________

_____Retinal Problems _____Surgery _____Double Vision ___________________

Do you have any of the following medical conditions? (**CHECK** all that apply)

_____High Blood Pressure _____Cancer ______Allergies (please explain)

_____Diabetes _____Pregnant ______________________

_____High Cholesterol _____HIV ______________________

Do any of your immediate family members (parents, siblings, grandparents) have any of the following eye/medical problems? (**CHECK** all that apply)

_____High Blood Pressure _____Cataracts _____Glaucoma

_____Diabetes _____Lazy Eye _____Retinal Problems

Please list any medications you are currently taking (prescription & over-the-counter) : _______________________

____

When was your last **PHYSICAL** exam?________PCP Doctor's Name ___________________________

PCP Office Info____

VISION Insurance Plan:____

Primary Card Holder:_____________________________________ DOB:__________________________

MEDICAL Insurance Plan:____

Primary Card Holder:_____________________________________ DOB:__________________________

How many hours a day do you spend doing computer work or paperwork?_______________________

If this is your first time here, how did you find out about our office? _____________________________

~CONTACT LENS INFORMATION~

Date of last CL checkup ____________________ Date you last wore your lenses: _________________

Average wear time (Hrs/Day) _______________ Current contact lens age: ______________________

Current CL Info R:____

L:____

Your cleaning and disinfecting method is: ____Renu ____Opti-free ____Revitalens ____Clear Care ____Boston System ____Other____________________________