Welcome To Our Office!

Dr. James P. Adcox
Optometrist

Please take a few moments to complete the following information.

Personal Information

Name: ____________________ ____ ____________________
(first) *(mi)* *(last)*

Address: ______________________________

City: ______________ State: ________ Zip: __________

Daytime Phone: ______________ Date of Birth: ______________

Parent or Guardian: ______________________________
(For patients under 18 years of age) *(Relationship)*

Reason for This Visit

☐ Routine Checkup
(No difficulty, seeing clearly and comfortably)

☐ Replace Current Glasses and/or Contacts

☐ Seeing problem *(Please explain below)*

____

Occupation and Hobbies

Please state your occupation and/or hobbies.

Ocular History

When was your last complete visual examination? ______________________

Have glasses ever been prescribed for you? ☐ No ☐ Yes If yes, do you still wear glasses? ☐ No ☐ Yes

How old are your present glasses? ______________

Have contact lenses ever been prescribed for you? ☐ No ☐ Yes Type: ☐ Hard ☐ Soft ☐ Gas Permeable

Are you interested in contact lenses? ☐ No ☐ Yes How old are your present contacts? ______________

Do you, or any family member have or ever had any of the following?:

	Self		Family Member(s)		Relation
Glaucoma	☐ No	☐ Yes	☐ No	☐ Yes	________
Cataracts	☐ No	☐ Yes	☐ No	☐ Yes	________
Amblyopia (Lazy Eye)	☐ No	☐ Yes	☐ No	☐ Yes	________
Eye Surgery	☐ No	☐ Yes	☐ No	☐ Yes	________
"*Crossed*" or "*Wall*" Eye	☐ No	☐ Yes	☐ No	☐ Yes	________

Eye Injury ☐ No ☐ Yes
(please describe the nature of injury and when it occured)

____

____

____

____

Medical History

Do you, or any family member have or ever had any of the following?:

	Self		Family Member(s)		Relation
Diabetes	☐ No	☐ Yes	☐ No	☐ Yes	________
High Blood Pressure	☐ No	☐ Yes	☐ No	☐ Yes	________
Allergy or Hay Fever	☐ No	☐ Yes	☐ No	☐ Yes	________
Arthritis	☐ No	☐ Yes	☐ No	☐ Yes	________
Other (*please explain*)	☐ No	☐ Yes	☐ No	☐ Yes	________

____

Are you currently taking any drugs, medications, or birth control pills?
☐ No ☐ Yes *(Please list all medications)*

____

____

Are you allergic to any drug(s) or medication(s)?
☐ No ☐ Yes *(Please list all medications)*

____

____

Method of Payment

☐ Cash ☐ Check

☐ Charge (Visa, Master Card, Sears, Discover, AmEx)

☐ Insurance *(Please state company, policy # and SS #)*

Company: ______________________________

Policy#: __________ SS#: ______________

Pupil Dilation

We provide to our patients, at no extra charge, routine pupil dilation as part of their comprehensive eye exam. This involves instilling drops to enlarge the pupils of your eyes, and allows the doctor to give a more thorough exam Please indicate your preference below:

☐ **Yes.** I do want my eyes dilated.

☐ I would like to discuss this matter with the doctor.

☐ **No.** I do not want my eyes dilated.

About Our Office

How did you find out about our office? ☐ Mailouts ☐ PhoneBook ☐ Television ☐ Newspaper ☐ Location

☐ Referred By: