**20/20 EYE CARE**
*A Family Eyecare Practice*
***Samia Idris, O.D.***

*10945 State Bridge Road*
*Suite 306*
*Alpharetta, GA. 30022*
*Office: 678-339-0423*

## PATIENT INFORMATION & HISTORY

Date: _____ Date of Birth: _____
Name: _____ Email: _____
Address: _____ Occupation: _____
City: _____ State: ____ Zip: _____ **Best contact #** _____

***** How did you hear about us?** _____

***** Are we able to text you when an order is ready for pick up?** Yes No # _____

**Vision Insurance Provider:** _____

I, the undersigned, acknowledge that it is the policy of this office that all payments are made at each visit and that I am responsible for payment/co-payment of services for the patient above.

Signature _____ Date _____

Reason for visit (Please check all that apply)

____ Routine Eye Exam ____ Broken or lost glasses ____ Referral
____ Blurred vision at distance ____ Blurred vision at near ____ Contact Lens Fit
____ Headaches or eye fatigue ____ Other

Please check any of the following that applies to yourself or any members of your immediate family.

| | SELF | FAMILY | | SELF | FAMILY |
|---|---|---|---|---|---|
| Diabetes | ____ | ____ | Glaucoma | ____ | ____ |
| High Blood Pressure | ____ | ____ | Cataract | ____ | ____ |
| Respiratory Problems | ____ | ____ | Eye/Head Injury | ____ | ____ |
| Kidney Disease | ____ | ____ | Blindness | ____ | ____ |
| Thyroid Disease | ____ | ____ | Flashes of Light | ____ | ____ |
| Arthritis | ____ | ____ | Spots in Vision | ____ | ____ |
| Cancer | ____ | ____ | Eye Injury | ____ | ____ |
| Headaches | ____ | ____ | Lazy/Turned Eye | ____ | ____ |
| Double Vision | ____ | ____ | Burning Eyes | ____ | ____ |
| Temporary Loss of Vision | ____ | ____ | Red Eyes | ____ | ____ |
| Itchy Eyes | ____ | ____ | Dry Eyes | ____ | ____ |
| Retinal Detachment | ____ | ____ | Other (Explain) | _____ | |
| Contact Lens Complications | ____ | ____ | _____ | | |

Please list any current medications you are taking:_____
Please list any known allergies (medical and/or environmental):_____
Do you wear glasses (please circle one)? Yes or No (If Yes, How old are they? _____ )
Circle what type: Single Vision Lined Bifocal/Trifocal Progressive (no-line) Reading Glasses
Date of last exam: _____

| Please check "Yes" or "No" to the following: | YES | NO |
|---|---|---|
| Do you work on a computer? | ____ | ____ |
| Do you have difficulty driving at night? | ____ | ____ |
| Do you have trouble with glare? | ____ | ____ |
| Do you work under fluorescent lighting? | ____ | ____ |
| Would you like to try contact lenses? | ____ | ____ |
| Did you know that a child should have an eye exam starting at age 3? | ____ | ____ |