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?	____	____