❑ Patient Information:

Last Name | First Name | MI | Date

Street Address | Apt. # | City | State | Zip

Date of Birth | Age | Soc. Sec. # | Home Phone | Bus. Phone | e-mail address*

❑ Male ❑ Female Ethnicity: ❑ White ❑ African American ❑ Hispanic ❑ Asian ❑ Pacific Islander ❑ Other

Insurance Information:

Primary Insurance | Employer | ID # | Subscriber (if different) | Subscriber Soc. Sec. # | Subscriber Date of Birth

Are you the: ❑ Subscriber ❑ Spouse ❑ Dependent Autho #_____ ❑ exam _____ copay

Dr. Varughese accepts assignment for insurance payment; we will make every effort to collect payment from your insurance company. Authorization does not guarantee payment from your insurance company, if we are unable to collect payment from your insurance company, you will be responsible for paying for any product or service delivered.

Patient Signature (parent guardian of a minor) _____

Date of last physical _____/_____/_____
Date of last eye exam _____/_____/_____

Have you been diagnosed with or treated for any of the following:

- ☐ Diabetes
- ☐ Cancer
- ☐ Hepatitis
- ☐ Stroke
- ☐ HIV or TB
- ☐ Depression
- ☐ Migraines
- ☐ Hypertension
- ☐ Thyroid Condition
- ☐ Heart Disease
- ☐ Other (please list):
- ☐ Respiratory Problems
- ☐ High Cholesterol
- ☐ Mental Disorder
- ☐ Sickle Cell Anemia
- ☐ Glaucoma
- ☐ Amblyopia
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Strabismus
- ☐ Retinal Detachment

Medications: (list any medications you are currently taking)

Are you taking birth control pills/shots/implants? Y N
Are you pregnant? Y N If yes, how many months?_____

Do you smoke? Y N
Do you drink alcohol? Y N
Have you had any substance abuse treatment? Y N

List any allergies (include medication allergies, environmental allergies, etc.):

Have you had any eye surgery or eye injuries requiring medical treatment? Y N
If yes, please describe:

Has an immediate family member been diagnosed with or treated for any of the following:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration

Contact Lenses: Have you ever worn contacts? Y N
Do you wear them now? Y N
How old is your present pair? _____
Are you interested in contact lenses? Y N
Type: _____

E-mail addresses are used to send "time for your exam" reminders and product updates specifically for you via e-mail. Dr. Varughese does not sell or lease our customers' addresses, phone numbers or e-mail addresses under any circumstances.

Do you experience any of the following:

- ☐ Squinting from sunlight
- ☐ Double Vision
- ☐ Recent Flashes
- ☐ Recent Floaters
- ☐ Excessive Burning
- ☐ Excessive Itching
- ☐ Excessive Tearing
- ☐ Unexplained Headaches

Have you been to Dr. Varughese before? Y N
Are you interested in the latest procedures to correct your vision (i.e., LASIK, PRK)? Y N

Lifestyle information:
What is your occupation? _____
Are you required to wear OSHA approved safety glasses at work? Y N
Do you use a computer? Y N
If yes, how many hours /day?_____

Please check hobbies or sports you participate in:

- ☐ Aerobics
- ☐ Archery
- ☐ Arts/Crafts
- ☐ Badminton
- ☐ Baseball
- ☐ Basketball
- ☐ Bicycling
- ☐ Boating/Sailing
- ☐ Bowling
- ☐ Camping
- ☐ Computers
- ☐ Cycling/Running
- ☐ Dancing
- ☐ Fishing
- ☐ Football
- ☐ Gardening
- ☐ Golf
- ☐ Hockey
- ☐ Home Improvement
- ☐ Horseback Riding
- ☐ Hunting
- ☐ Jet Skiing
- ☐ Lacrosse
- ☐ Mountain Climbing
- ☐ Music
- ☐ Racquetball
- ☐ Reading
- ☐ Rollerblading
- ☐ Scuba Diving
- ☐ Snorkeling
- ☐ Skating
- ☐ Snowmobiling
- ☐ Snow Skiing
- ☐ Soccer
- ☐ Squash
- ☐ Stamp/Coin Collecting
- ☐ Swimming
- ☐ Tennis
- ☐ Track & Field
- ☐ Volleyball
- ☐ Walking
- ☐ Water Skiing
- ☐ Weight Lifting
- ☐ Windsurfing/ Surfing
- ☐ Woodworking
- ☐ Writing
- ☐ X-Country Skiing
- ☐ Other (please list):

For office use only:

- ☐ ROS
- ☐ AOX3