Morgantown Eye Care Center
Dr. Miriam Pearson
Optometrist

Patient's name: Ms./Mrs./Mr. _____

Address: _____

Phone: _____ *Date of Birth:* _____ *Age:* _____ *S.S.N.* _____-_____-_____

Occupation: _____ *email address:* _____

Employer/School: _____ *Work Phone:* _____

Emergency contact: _____

How did you hear about Morgantown Eye Care Center? _____

Do you have an insurance plan with vision benefits? _____ *Co. name and policy number?* _____

Do you have medical health insurance? _____ *Co. name and policy number?* _____

Cell phone: _____ *Do you prefer we contact you by: mail* _____ *phone* ___ *email* _____

GENERAL HEALTH HISTORY: (Please check those conditions that apply to you) _____ High Blood Pressure
_____Allergies _____Diabetes _____Arthritis _____Drug Sensitivities _____Headaches
_____Eye Diseases _____Heart Disease _____Glaucoma _____Cataracts _____Eye or Head Injuries
_____ Smoke - if so, how much? _____

FAMILY HEALTH HISTORY: (Blood relatives who have the following conditions)
_____Diabetes _____High Blood Pressure _____Heart Disease _____Glaucoma _____Eye Disease _____Blindness

Family Physician: _____ *Date of last General Health Exam:* _____
Are you presently being treated for any medical conditions? _____
If so, what conditions? _____
Please list any medications you are taking: _____
When was your last eye exam? _____ *Who was the Doctor?* _____
Have you ever worn glasses? _____ *Do you wear glasses now?* _____
Are you having any vision problems with seeing at a distance? _____ *Seeing close to you?* _____
Do you experience symptoms such as: Sensitivity to sunlight? _____ *Difficulty with night vision?* _____
Dryness ? _____*Burning?* _____*Extra Tearing?* _____*Itching?* _____*Twitching Eyelids?*_____
Have you ever worn contact lenses? _____ *If so, what type?* _____
Are you interested in being fitted for contact lenses? _____
Do you ever wear your contact lenses to sleep or nap? _____
Have you ever received vision training or eye excercises? _____
Do you use a computer? _____ *If so, how many hours per day?* _____
In what hobbies or sports do you participate? _____
What is the main reason for your visit today? _____

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

Signature: _____ *Date:* _____

Telephone: 610-286-0206 FAX: 610-286-5525