# Morgantown Eye Care Center
## Dr. Miriam Pearson
Optometrist

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

*Address:* _____

*City* _____ *State* _____ *Zip* _____

*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?*_____

Verification of benefits does not guarantee payment by the insurance company. The patient is responsible for all charges.

*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?* _____ *Family Physician Phone #:*_____
*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:* _____