W. REED KINDERMANN, MD AND ASSOCIATES **DATE**_____

PATIENT NAME _____
(last) (first) (middle) (male) (female)

STREET ADDRESS_____
(street) (city) (state) (zip)

HOME PHONE _____WORK PHONE _____CELL PHONE_____

DATE OF BIRTH _____AGE_____ SOC. SEC #_____ EMAIL ADDRESS_____

EMPLOYER/OCCUPATION_____

INSURED'S NAME AND ADDRESS_____

INSURED'S SOC. SEC. #_____ INSURED'S DATE OF BIRTH_____

HAS ANYONE FROM YOUR FAMILY BEEN TO OUR OFFICE_____
(NAME & RELATIONSHIP)

WHO REFERRED YOU TO OUR OFFICE / HOW DID YOU LEARN ABOUT US ?_____

_____

YOUR MEDICAL DOCTOR_____
(name) (address) (phone #)

WHEN WAS YOUR LAST EYE EXAM ? _____EXAM BY DR._____

DO YOU WEAR GLASSES?_____ YES _____ NO_____ DISTANCE READING_____ BIFOCAL_____

DO YOU / HAVE YOU EVER WORN CONTACT LENSES? _____YES _____NO _____HARD _____SOFT

HAVE YOU EVER HAD NON-SURGICAL EYE TREATMENT? _____YES _____NO IF YES, WHICH EYE, WHEN, WHY?

_____

HAVE YOU EVER HAD SURGICAL EYE TREATMENT? _____YES _____NO IF YES, WHICH EYE, WHEN, WHY?

_____

REASON FOR YOUR VISIT TODAY?_____

PLEASE ***CIRCLE*** ANY SYMPTOMS BELOW THAT APPLY TO YOU AND DESCRIBE BELOW:

PAIN (PLEASE DESCRIBE WHICH EYE, DURATION, INTENSITY):_____

_____

(LOSS OF VISION) (BLURRED VISION) (DISTORTED VISION) (HALOS) (GLARE) (TROUBLE: READING/ DRIVING)
(DOUBLE VISION /ONE EYE/BOTH EYES) (DRI/NESS) (TEARING) (MUCOUS DISCHARGE) (BURNING)
(INFECTION) (PINK EYE) (EYELID PROBLEM _____RIGHT_____LEFT) (STYE /IIORDEOLUM) (CHALAZION)
(FLASHES) (FLOATERS) (CURTAIN) (LOSS OF SIDE/UP/DOWN VISION) (PRESSURE) (IIEADACHE)
DESCRIBE / OTHER_____

ALLERGIES: NONE _____YES (PLEASE LIST): _____

_____