WESTHEIMER VISION

A relationship of trust • A lifetime of care

Welcome To Our Office

Patient Information

Today's Date: ____________ Preferred Name: ________________

Circle One: Mr. Mrs. Ms. Other: _______ Gender: M F

Name: ____
First Initial Last

Date of Birth: __________ Height: _________ Weight: _________

Address: ____

City: ______________________ State: _______ Zip: __________

Phones: Home: ________________ Work: ________________

Cell: ____________________ Carrier: ____________________

E-Mail: ____

Preferred Communication: ❒ Home Phone ❒ Work Phone
❒ Cell ❒ Email ❒ Text

Marital Status: S M W Spouse's Name: ____________________

Race:

- ❒ American Indian/Alaska Native
- ❒ Asian
- ❒ Black/African American
- ❒ Hispanic or Latino
- ❒ Native Hawaiian/Other Pacific Islander
- ❒ White

Other Race: ____

Preferred Language: __________________________________

Occupation: ____

Employer: ____

Insured/Parent: ______________________________________

Ins. ID/SS #: _______________________________________

Are other members of your family patients here? ❒ Yes ❒ No

Their Names: ____

____

Name(s) of individual(s) that have permission to receive your health information.

____

____

Lifestyle Questions

Do you smoke: ❒ Yes ❒ No ❒ Former Smoker

Alcohol use: ❒ None ❒ Daily ❒ Occasionally

Computer use: ❒ None ❒ Daily ❒ Occasionally

Hours per day: __________

❒ Wear glasses ❒ Wear sunglasses

❒ Wear contact lenses ❒ Solutions used: __________

What are your hobbies? ______________________________

____

What sports do you play? ____________________________

____

How Did You Find Out About Our Office?

Are you a: ❒ New Patient ❒ Former Patient

❒ Another Patient: Who? ______________________________

❒ Insurance Website

❒ Internet: Which website? ____________________________

❒ Other: ____

Eye History

(check those that apply)	Self	Family
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injuries		
Retina Problems		
Strabismus (eye turns in or out)		
Amblyopia (lazy eye)		
Eye Surgery		
Dry Eye		
Color Blind		

Medical History

(check those that apply)	Self	Family	(check those that apply)	Self	Family
High Blood Pressure			Neurological/Psychological		
Heart Disease			Diabetes		
Ear, Nose, Throat			Thyroid		
Respiratory			Allergies/Asthma		
Gastrointestinal			Arthritis/Lupus		
Genitourinary			Cancer		
Muscles, Bones, Joints			Weight Loss		
Skin Disorders			Other		

Medications: ____

____

Drug Allergies: ____

Pharmacy: ______________________________ Phone Number: ______________

Address/Cross Street: ____