SHIGIO OPTOMETRIC GROUP

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Date of Birth _____ Age _____
Sex Male Female
Patient's SSN XXX-XX- _____
Address _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

Email Address _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

Notification Preference? Phone Email

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

- ☐ Another Doctor
- ☐ Insurance List
- ☐ Saw Sign/Building
- ☐ Newspaper/Radio/TV
- ☐ Yellow Pages: Which Directory? _____
- ☐ Web Page: Which Web Site? _____
- ☐ Other _____

The doctors and staff at Shigio Optometric Group feel that excellent vision is the foundation to a high quality of life. We are dedicated to providing you with the most advanced quality of eye care and eye wear available, in a friendly and efficient environment. Our mission is to enhance and preserve your vision throughout your lifetime.

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN XXX-XX- _____
Subscriber DOB _____

Secondary Vision Insurance _____
Subscriber Name _____
Subscriber SSN XXX-XX- _____
Subscriber DOB _____

Will you need documentation for a flex spending account?

☐ Yes ☐ No

Lifestyle Questions

Do you….(check box if your answer is yes)

- ☐ …work at a computer?
- ☐ …think you might benefit from thinner, lighter lenses?
- ☐ …spend time outdoors? How much? _____ hrs/week
- ☐ …have prescription sunwear?
- ☐ …have interest in a non-surgical approach to vision
- ☐ …prefer not to wear your glasses at times? When? _____
- ☐ …have more than 1 pair of current Rx eyewear?

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Blurry Vision	☐ Cataracts	☐ Crossed eye/Eye turn
☐ Eye Infections	☐ Flash of Light	☐ Glaucoma
☐ Headaches	☐ Itchiness	☐ Macular Degeneration
☐ Tearing	☐ Burning	☐ Retinal Detachment
☐ Double Vision	☐ Eye Injury	☐ Corneal Abrasions
☐ Grittiness	☐ Iritis/Uveitis	☐ Occasional Dryness
☐ Lazy Eye	☐ Floaters/Spots	☐ Sunlight Sensitivity

- ☐ Trouble seeing at night
- ☐ Other eye disorders _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician _____
City/Location _____
Date of Last Physical Exam _____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins and birth control pills _____
_____
_____

Allergies to medications? ☐Yes ☐No
If so, what medications? _____
_____

Have you had any surgeries? ☐Yes ☐No
Do you use cigarettes/tobacco, alcohol, or other substances? ☐Yes ☐No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Thyroid	☐	☐

Patient Eye History

Date of Last Eye Exam _____
By Whom? _____

Have you ever tried contact lenses? ☐Yes ☐No

Do you currently wear contact lenses? ☐Yes ☐No
What kind? _____
Solutions used? _____

Are you satisfied with the vision and comfort of your contact lenses? ☐Yes ☐No

If you wear bifocals, do the lines or head tilting bother you? ☐Yes ☐No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

☐No ☐Yes (Please check boxes)

	Relationship (Mother's or Father's side)
☐ Blindness	_____
☐ Cataracts	_____
☐ Corneal Problems	_____
☐ Diabetes	_____
☐ Glaucoma	_____
☐ Heart Disease	_____
☐ Lazy Eye	_____
☐ Macular Degeneration	_____
☐ Retinal Problems	_____

Thank you for your trust in our office!

Ronald S. Shigio, O.D.
Lauri K. Shigio, O.D.