


# Great Lakes Optometry Patient Info Check-In

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone Number #1: \_\_\_\_\_ Cell Landline Is it okay to text this number? Yes No  
Phone Number #2: \_\_\_\_\_ Cell Landline Is it okay to text this number? Yes No

Vision Plan: _____ Primary Card holder Name: _____ Date of birth: _____ Last 4 of card holder social security#: _____
Medical Insurance: _____ Primary Card holder Name: _____ Date of birth: _____
 Primary Medical Doctor: _____
Medications: (We can copy a medication card instead of writing it! Just let us know!)
Allergies:
<u>Medical</u> Conditions your medications are for:
<u>Eye</u> Conditions previously diagnosed or actively managed (circle): NONE Cataracts Glaucoma Eye turn/lazy eye Iritis/Uveitis Macular degeneration Retinal tear/detachment Keratoconus Diabetic retinopathy Dry eye syndrome Other: _____
When was your last eye exam or eye checkup?: _____ Where?: _____
Eye Surgeries:
There is a family history of (please check): <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease      Other: _____
Social History (please check): Alcohol use: <input type="checkbox"/> None <input type="checkbox"/> Drinks socially <input type="checkbox"/> Daily Tobacco use: <input type="checkbox"/> None <input type="checkbox"/> Former Smoker <input type="checkbox"/> Current smoker
Do you wear contact lenses? No      Yes
How much time per day do you spend on digital devices (computer, phone, tablet, etc.)? None   1-3 Hours   4-7 Hours   8-12 Hours   12 hours or more
What is your occupation?
How did you find out about us?