

Dr. George J. McArdle

WELCOME BACK TO OUR OFFICE

Please take a few minutes to complete this form before your first visit. This will help insure your information is accurate and save time for you and our staff. Remember to email it back, or print and bring it with you along with your vision and health insurance cards. We look forward to seeing you.

Mr. Miss Mrs. Ms.

Male Female

First Name Middle Initial Last Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone (include area code) Work Phone

E-mail Address Spouse or Parent(s) Name Person Responsible for Account (Must sign at bottom)

School Name Mr. Ms. Teacher's Name Grade

What is the main reason for today's exam? _____ When was your last exam? _____

How were you referred to our office?

Phone Book School Advertisement Patient (Please name) _____
 Insurance Listing Drive By Other _____ Doctor (Please name) _____

Eye Insurance Information

Name and Address of Eye Insurance Company City State Zip

Male Female

Insured's First Name Middle Initial Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured: Self Spouse Child Other **Patient Status:** Single Married Other
 Full-time Student Part-time Student Employed

Health Insurance Information

Name and Address of Health Insurance Company City State Zip

Male Female

Insured's First Name Middle Initial Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured: Self Spouse Child Other

PLEASE READ: In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Signature

Date

Dr. George J. McArdle

PATIENT HISTORY AND INFORMATION

Name _____

Date _____

Visual History

Current Occupation _____ Years _____ Employer _____

Do you use a computer? Yes No How many hours/day? _____ Distance from computer? _____

Do you drive? Yes No Mileage to work each way? _____ Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No

Do you have problems with night vision? Yes No

Spectacle Lens History

Do you currently wear glasses? Yes No Since _____

Type of glasses? Full Time Part Time Distance Close

Glasses Owned: Single Vision Bifocals Trifocals Back-up Glasses Safety Glasses Sports Glasses Progressive

Have you had trouble in the past with glasses? Yes No _____

Do you wear sunglasses? Yes No Are your sunglasses your current prescription? Yes No

Contact Lens History

Have you ever tried to wear contact lenses? Yes No Reason for stopping _____

Do you currently wear contact lenses? Yes No Since _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

Type and brand of contact lenses _____ Today's wearing time _____

How many hours/day? _____ How many days/week? _____

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

Right Left Right Left Right Left
Lens Comfort: _____ Distance Vision: _____ Near Vision: _____

What solutions do you use? Cleaner: _____ Disinfectant: _____ Enzyme: _____

Social History

Do you use nutritional supplements (vitamins, etc)? Yes No

Do you engage in regular exercise? Yes No

Do you drink alcohol? If yes, how much/often? No Occasional 1 per day 2-3/day 4+/day

Do you smoke? If yes, how much/often? No Occasional 1 per day 2-3/day 4+/day

Hobbies/Interests: _____

Special Eyewear Needs

Computer (special prescriptions, special anti-glare tints or coatings)

Occupational (mechanics, plumbers, pilots)

Safety Glasses (gardening, woodworking, welding)

Sports/Hobbies (racquet sports, motorcycle)

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MEDICAL HISTORY QUESTIONNAIRE

Name _____

Date _____

Eye History

- Headaches, Glare/Light Sensitivity, Tired Eyes, Lazy Eye, Burning, Dryness, Excess Tearing/Watering, Eye Pain or Soreness, Foreign Body Sensation, Infection of Eye or Lid, Itching, Mucous Discharge, Drooping Eyelid, Redness, Sandy or Gritty Feeling, Crossed Eyes, Blurred Vision (Distance), Blurred Vision (Near), Distorted Vision (Halos), Double Vision, Floaters or Spots, Fluctuating Vision, Loss of Vision, Loss of Side Vision

General Health Condition

- Fever, Weight Loss, Ears, Nose, Throat, High Blood Pressure, Respiratory (Asthma), Gastrointestinal, Kidney, Muscles, Bones, Joints, Skin, Neurological (MS), Psychiatric, Anxiety, Depression, Insomnia, Diabetes, Thyroid, Blood/Lymph (Cholesterol), Allergic/Immunologic

Past illnesses or injuries: _____

Past surgeries: _____

Current medications: _____

Medicines that cause reactions or sensitivities: _____

Specific allergies: _____

Family History

- Lazy Eye, Blindness, Cataract(s), Color Blindness, Glaucoma, Macular Degeneration, Retinal Detachment, Eye Turn, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Lupus, Stroke, Thyroid Disease, Others

When complete, you have three options:

- 1) Simply click the SUBMIT button to email this form to Dr. McArdle/trli optics.
2) If you prefer, you can save the completed document on your computer and attach it to an email. Send it to info@drmcardle.com.
3) You can print out and complete the form and bring it with you to your appointment.