TRUE VISION
OPTOMETRIC GROUP

112 Val Verde Street
Altus, OK 73521
580-482-0051

212 S Main Street
Hobart, OK 73651
580-726-3301

500 N Washington Ave
Weatherford, OK 73096
580-772-3232

Today's Date: _____

First Name: _____MI_____ Last Name_____

Address_____City_____State_____Zip_____

Home#( )_____ Cell#( )_____ Work#( )_____

DOB_____/_____/_____ SS#_____

Male_____ Female _____ Language_____ Race/Ethnicity_____

E-mail address_____

Emergency Contact Name_____ #( )_____

INSURANCE_____ **ID#** _____

PATIENT EYE INFORMATION

Eye surgeries/Injuries_____ Date(s)_____

Head injuries_____ Date(s)_____

Date of last eye exam_____ Were you dilated?_____

Have you or do you have any of the following:

Retinal Detachment yes/no
Blurred Vision yes/no
Seizures yes/no

Macular Degeneration yes/no
Dry Eyes yes/no
Other _____

Glaucoma yes/no
Cataracts yes/no

How did you hear about us?_____

~Please turn over to complete back portion~

FAMILY HISTORY

Diabetes Yes/No Relation_____ **Macular Degeneration** Yes/No Relation_____

Glaucoma Yes/No Relation_____ **Retinal Detachment** Yes/No Relation_____

Cataracts Yes/No Relation_____ **High Blood Pressure** Yes/No Relation_____

Cancer Yes/No Relation_____ **Blindness** Yes/No Relation_____

MEDICAL HISTORY

Do you have diabetes? YES_____ NO_____ Type?_____

Do you have problems/symptoms related to any of the following: (please circle yes or no)

Headaches	Yes/No	**Blood**	Yes/No
High Blood Pressure	Yes/No	**Ears/Nose/Throat**	Yes/No
Heart	Yes/No	**Gastrointestinal**	Yes/No
Respiratory	Yes/No	**Skin**	Yes/No
Muscles/Skeletal	Yes/No	**Nervous/Nerves**	Yes/No
Urinary	Yes/No	**Endocrine(glands)**	Yes/No
Lymph	Yes/No	**Immune**	Yes/No
Fainting/Dizziness	Yes/No	**Cancer**	Yes/No

If **YES** to cancer, what type/where?_____

Other_____

Are you allergic to any medication? **Yes/No** If **YES**, what & what reaction? _____

Current Medication: _____

Surgery(s) and the dates:_____

Who is your Family Physician?_____ Number (____)_____