Dr. John E. Anderson
Dr. Terri D. Anderson
Optometrists

Anderson Eyecare

"Clearly Focused on You"

3786 Central Pike Suite 118
Hermitage, TN 37076
(615) 883-9595 (fax 883-9691)

Vision & Medical History

We would like to Welcome You Back to Anderson Eyecare.
Please take the time to complete this brief update of your information.

Emergency Contact ____________________Relation ____________ Emergency Contact Phone #________________________

Marital Status of **Patient**: Single Married Other **Patient**: Employed: Full Time Part Time Not Employed Student Retired

May we send you a text or email messages for appointment reminders, arrival of glasses, contact lenses, etc…? Yes No

Medical History: (Please ☑ at least one box/line.)

	Self	Family	No One
Diabetes	❑	❑	❑
High Blood Pressure	❑	❑	❑
High Cholesterol	❑	❑	❑
Arthritis	❑	❑	❑
Glaucoma	❑	❑	❑
Macular Degeneration	❑	❑	❑
Eye Disease	❑	❑	❑
Respiratory Problems	❑	❑	❑
Other	❑	❑	❑

Medical History (Patient Only): (Please ☑ or circle one / line.)

	Currently	Previously	Never
Cataracts	❑	❑	❑
Allergies	❑	❑	❑
Head/Eye Trauma/Surgery	❑	❑	❑
Asthma	❑	❑	❑
Pregnant or Nursing	❑	❑	❑

Head Aches (circle one) Rare Occasional Frequent

Current Medications (Rx & Over-the-Counter):

Name of Medication

❑ Antihistamine - ______________________________
❑ Blood Pressure Meds. - ______________________
❑ Diabetes Meds. -_____________________________
❑ Headache Meds. -____________________________
❑ Oral Contraceptives - ______________________
❑ Eye Drops -_________________________________
❑ ____
❑ ____
❑ I do not take prescription or "Over the Counter" meds.

Examination History:

Are you allergic to any medications? _________________

Name of your Physician: ______________________
Phone #: ______________________

Medical Information: (O P T I O N A L)

Do you use tobacco products? ❑No ❑Occasional ❑Often
Do you drink alcohol? ❑No ❑Occasional ❑Often

Current Vision Assistance: (☑ Please mark any that you use.)

❑ Glasses ❑ Reading Glasses ❑ Magnifier
❑ Disp. Contacts ❑ 1 Year Contacts ❑ Hard Contacts

Patient Vision History: (☑ Please mark any you experience.)

❑ Distance Blur ❑ Watery Eyes ❑ Floaters
❑ Near Blur ❑ Dry Eyes ❑ Flashes of Light
❑ Glare ❑ Itchy Eyes ❑ Blackouts
❑ Tired Eyes ❑ Burning Eyes ❑ Other

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Demographic History (Please circle the one applies best to you.)

- Preferred Language: English Spanish Other_____
- Ethnicity: Not Hispanic or Latino Hispanic or Latino Native Hawaiian/Other Pacific Island
- Communication Preference: Email Postal Telephone
- Race: American Indian or Alaska Native Asian Black or African American Hispanic White Native Hawaiian/Other Pacific Islander Other_______________________

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Your Examination Needs Today: (Please ☑ all that apply.)

❑ Thorough Vision & Eye Health Exam (includes glasses Rx)
❑ Limited Exam for Specific Eye Problem
❑ Contact Lens Fitting & Training for New Wearer
❑ Contact Lens Evaluation & Renewal of Prescription
❑ Surgery Pre-op or Consultation
❑ Other :

Your Eyewear/Contacts Needs Today: (Please ☑ all that apply)

❑ I would like to order new glasses today.
❑ I would like to order contacts today.

I hereby give my consent to Dr. Anderson to provide eyecare services for me and/or my family and to obtain records from my current and/or previous doctors. I also authorize the release of information and payment of vision/medical benefits, if I choose to use an insurance plan for which the doctors are providers.

SIGNATURE Date

History Reviewed by:_____________________

Date Reviewed:_________________________