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

Name _____

Street _____

City _____ State _____ Zip _____

Home Phone_____

Day Phone _____

Cell Phone _____

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

Email Address _____

Employer (or school)_____

Occupation (or grade) _____ Full Time / Part Time

Date of Birth _____ Age_____ Sex : M F

Social Security # _____ Marital Status: Single Married Other

Emergency Contact _____Relation _____

Emergency Contact Phone # ☎ _____

Medical Insurance _____

Vision Insurance (if applicable) _____

When was your last eye exam? _____

Name of the eye doctor? _____

How did you hear about our office? _____

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

- ❑ Antihistamines_____
- ❑ 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:

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

_____

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_____

_____

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