Hendrix & McGuire OPTICAL
Since 1955

WELCOME TO HENDRIX & MCGUIRE OPTICAL

Please present your insurance card at the front desk.

Patient Name _____ Date of Birth _____
Occupation (or grade) _____ Age _____ Male _____ Female _____
Street Address _____ Home Phone ( ) _____
City _____ State _____ Zip Code _____ Daytime Phone ( ) _____
Accompanying parent/caregiver/interpreter name: _____
How did you hear about us? _____

PLEASE CHECK ALL THAT APPLY

- ☐ I had a previous eye exam at this location.
- ☐ I am a new patient. My last eye exam was _____ ago.
- ☐ I am here for a diabetic eye exam.
- ☐ I am here for a routine eye exam for glasses.
- ☐ I am here for a contact lens exam, AND
  - ☐ I brought my contact boxes or previous Rx info, or want to try new lenses.
  - ☐ I don't have my old contact lens Rx info, or want to try new lenses.
  - ☐ I will be trying contacts for the first time.
- ☐ I am experiencing the following symptoms:

PLEASE LIST, OR CIRCLE 'NONE'

Medications you take: NONE _____

Medications you are allergic to: NONE _____

PLEASE CHECK ALL THAT APPLY

- ☐ Allergies (seasonal/environmental)
- ☐ Cancer (type: _____)
- ☐ Diabetes
- ☐ Head/neck injury
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Pregnant or ☐ nursing
- ☐ Stroke
- ☐ Thyroid or ☐ pituitary disorder
- ☐ Other: _____
- ☐ Cataract surgery
- ☐ Double vision
- ☐ Eye injury (at age _____)
- ☐ Eye muscle surgery
- ☐ Glaucoma
- ☐ Lasik or other vision correction surgery
- ☐ Lazy eye
- ☐ Macular degeneration
- ☐ Family history of eye disease/blindness
- ☐ Other: _____

Please turn off your cell phone before entering the exam room. Thank you!

Reviewed by Dr. _____ Date _____ Ins. _____