Hancock Eye Associates

Welcome to our Office — Dr. Elaine R Scott — Dr. Christa L Walling

Date: / /

Personal Information

Sex: ☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Name: Age: Birthdate: / /

Address: City: State: Zipcode:

Home Phone: Work Phone: Occupation: Employer:

Name of Parent/Spouse: Grade If Student

Have we seen other family members? Yes ☐

E-mail Address: S.S. # Whom? No ☐

Medical and Visual History

Name of Physician: Last Eye Doctor: Last Eye Exam:

List all Medications you are taking:

☐ None

List any Medication Allergies:

☐ None

Check any Medical Conditions that apply to you:

☐ None ☐ Allergies ☐ Ear/Nose/Throat Problems ☐ Arthritis

☐ Headaches ☐ Cancer ☐ Psychiatric Problems ☐ Heart Disease ☐ Other

☐ Diabetes ☐ Gastrointestinal Problems ☐ High Blood Pressure ☐ Lung Disease

Check any Eye Conditions that apply to you:

☐ Eye Surgery ☐ Glaucoma ☐ Cataracts ☐ Dry Eye ☐ Macular Degeneration

☐ Lazy Eye ☐ Light Flashes ☐ Floaters ☐ Turned Eye ☐ Past Eye Injury

Check Conditions that are present in other family members (Parents, Grandparents, Siblings)

☐ Glaucoma ☐ Heart Disease ☐ High Blood Pressure ☐ Other _____

☐ Diabetes ☐ Cancer ☐ Macular Degeneration ☐ None

Contact Lens History

☐ Currently Wearing Contacts ☐ Not Interested in Contacts

☐ Would Like to know if I could wear Contacts ☐ Problems with Contacts _____

Type of Contacts Worn

☐ Daily Wear ☐ Rigid Gas Permeable ☐ Disposable/Frequent Replacement

☐ Extended Wear ☐ Bifocal ☐ Other _____

Activities and Interests

☐ Contact Sports ☐ Computer ____ hrs./day ☐ Basketball/Volleyball ☐ Reading

☐ Sewing/Crafts ☐ Baseball/Softball ☐ Soccer ☐ Other _____

How did you find out about our office?

☐ Insurance List ☐ Phone Book ☐ Newspaper ☐ Direct Referral ☐ Other _____