New Patient Consult

CHART#: _____
DATE: _____
UPDATED BY: _____

CAMPBELL CUNNINGHAM
LASER CENTER

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security #: _____

Sex: ☐ Male ☐ Female Race: _____ Hispanic: ☐ Yes ☐ No

Physical Address: _____

City: _____ State _____ Zip _____

Home #: _____ Cell #: _____ Work #: _____

Employer: _____ Occupation: _____

Vision Insurance: _____ Email: _____

Emergency Contact: _____ Phone #: _____

MEDICAL AND OCULAR HISTORY

Y	N		Y	N		Y	N	
		Asthma			Iritis/Uveitis			**Do any family members have:**
		Corneal Ulcers			Keratitis			Glaucoma
		Diabetes			Keratoconus			Cataracts
		Detached/Torn Retina			Lupus			Retinal Detachment
		Dry Eyes			Rheumatoid Arthritis			Keratoconus
		Eye Surgery			Connective Tissue Disorder			Corneal Transplant
		Glaucoma			Pregnant/Nursing			Macular Disease
		Herpes Simplex			Sinus/Allergies			Diabetes

List all eye surgeries, injuries, or diseases you have had:

_____

_____

List all elective or cosmetic surgeries you have had:

_____

_____

List all medical problems you have:

_____

_____

List all oral or injected medications you are taking:

_____

_____

List any medications you are allergic to:

_____

_____

If an eye doctor suggested you see us, please provide the doctor's name: _____

New Patient Consult (Cont.)

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If not referred by a doctor, how did you hear about us? _____

List activities and hobbies you enjoy:

_____

How does your vision impact your quality of living now?

_____

_____

What are your biggest problems with contacts and glasses?

_____

_____

With glasses or contacts, how much nighttime glare or halos do you currently have?

☐None ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

Please check any other reason(s) for problems with glasses or contacts:

	Poor Comfort		Nuisance		Poor Peripheral VIsion
	Poor Cosmetic Experience		Dependence		Safety/Security
	Poor Vision Quality		Restricts Physical Activity		Occupational Limitations

Other: _____

FOR OFFICE USE ONLY

AR: OD: _____ OS: _____

GLS RX: OD: _____ OS: _____ Age of Glasses: _____

CL RX: OD: _____ OS: _____ Type of Contacts: _____ Last Worn: _____

NOTES:

_____

_____

_____

_____

Scheduled with: _____ Preop: _____ Sx: _____ ALLSCRIPTS_____ MD Prospects _____

Discussed:
Date to come out of contacts: _____ Payment/Financing: _____ Recovery Time: _____ What to expect Pre-op: _____
Need for readers: _____ Lead Source: _____

CONSULTATION PERFORMED BY: _____