CARROLLTON
FAMILY VISION
PRACTICE
Paul H. McRae, O.D.
Optometrist
Welcome to our office

Date _____

Patient's Name _____ Date Of Birth _____

Address _____

City _____ State _____ Zip _____ Home Phone _____

Occupation _____ SS# _____

Person responsible for payment _____ Relationship _____

Employer _____ Work Phone _____

Whom may we thank for refering you to our office? _____

Family ___ Friend ___ Phone Book ___ Newspaper Ad ___ (What Newspaper? _____

Other ___ (If other please list _____

What problem are you having with your eyes? none ___ distance blur ___ near blur ___
small print ___ glare ___ eye strain ___ redness ___ night blindness ___ headaches ___
other (please explain) _____

	YES	NO
When was your last eye examination? _____		
Do you wear glasses? How old are they? _____	☐	☐
Have you ever seen Dr. McRae before? _____	☐	☐
Have you ever had eye surgery? _____	☐	☐
Have you ever had any injury to your eyes? _____	☐	☐
Have you ever had crossed eyes or an eye that turns out? _____	☐	☐
Are you presently being treated for any medical problems? _____	☐	☐
Are you presently taking any medications? _____	☐	☐
If so, please list them. _____		
Do you use a computer? _____	☐	☐
If so, do you experience any of the following while at a computer?		
eye strain ___ headaches ___ eye pain ___ burning/tired eyes ___		
Are you allergic to anything? What? _____	☐	☐
Do you or any family member have cataracts? Who? _____	☐	☐
Do you or any family member have glaucoma? Who? _____	☐	☐
Do you or any family member have high blood pressure? Who? _____	☐	☐
Do you or any family member have diabetes? Who? _____	☐	☐
Do you have any type of heart disease? What type? _____	☐	☐
Have you or any family member ever had a heart attack? Who? _____	☐	☐
Have you or any family member ever hah a stroke? Who? _____	☐	☐
Do you have asthma or any other breathing disorder? If so, what? _____	☐	☐
Do you have frequent headaches? When? _____	☐	☐
Do you ever see double? When? _____	☐	☐