PETER J. KURTZ, O.D.

Welcome to our office:

Date _____ ss number _____

Patient's Name _____ Age _____ Date of Birth _____

Address _____ City _____ Zip _____ Phone _____

Occupation _____ if student, grade _____ School _____

Employer _____ Address of Employer _____ Phone _____

Name of Parent or Spouse _____

WHO WILL PAY FOR THIS ACCOUNT? _____

ADDRESS? _____

Preferred Payment Method: Cash _____ Check _____ Insurance _____ Medi-Charge _____

Approximate date of last eye examination _____ by Doctor _____

GENERAL HEALTH (past or present)

____ allergies	____ skin conditions	____ tuberculosis (TB)
____ diabetes	____ heart disease	____ eye or head injuries
____ drug sensitivities	____ seizures	____ glaucoma
____ high blood pressure	____ eye diseases	____ headaches

FAMILY HISTORY (blood relatives who have --)

____ diabetes	____ glaucoma	____ high blood pressure
____ heart disease	____ cataracts	
____ eye diseases	____ blindness	

Hobbies/Activities _____

Family Physician _____ Address _____

Are you presently being treated for any medical conditions? _____

If so, what conditions? _____

Last general health exam (date) _____

Are you presently taking any medications? (including hormones or birth control pills) _____

Please list present medications _____

_____

Do you feel your vision problems occur at distance? _____

near? _____

Do you experience eye strain such as: burning _____

itching _____

tearing _____

twitching eye lids _____

light sensitivity _____

Have you ever worn contact lenses? _____ If so, when were they prescribed? _____

Have you ever received vision training or eye exercises? _____

Who may we thank for referring you to this office? _____