615.907.0433. • Murfreesboroeyecenter.com 1720 Old Fort Pkwy C160 • Murfreesboro, TN 37129

INTAKE FORM (Please fill this form out in its entirety)

Patient Name: ___________________________ Birth Date: ________________ Age: ________ Gender: _________

Home Phone: ____________________ Cell Phone: ______________________ Email: ___________________________

Mailing Address: ______________________________________ City: _____________ State: _______ ZIP: _________

REASON FOR VISITING OUR OFFICE TODAY: *(please check one)*

____ Comprehensive Eye Exam ____ Contact Lens Exam ____ Other: ____

Have you had an eye injury/surgery? Y N If YES, type of injury/surgery and date:___________________________

Are you currently pregnant? Y N Any Tobacco Use? Y N

Primary Physician Name: ____ Phone: ____________________

Are you currently taking any medication? Y N If YES, list the medication: _________________________________

____

Are you allergic to any medication? Y N If YES, list the medication: ______________________________________

____

OCULAR/MEDICAL HISTORY: *(please check all that apply):*

	SELF	FAMILY		SELF	FAMILY		SELF	FAMILY
Macular Degeneration			Hypertension			Cancer		
Cataracts			Cholesterol			Stroke		
Glaucoma			Heart Disease			Heart Defects		
Retinal Detachment			Thyroid			Seizures		
Diabetes			Arthritis			Multiple Sclerosis		

For any “Self” checkmarks above, please write year of diagnosis and treatment:__________________________________

____

By signing below, I attest to the truthfulness and accuracy of the information provided above.

Patient Signature: ____ Date: ______________