

**Academy Eye Centers, Optometry, PA**  
*Danford E. Raynor, Jr., O.D. Ryan E. Snipes, O.D.*  
*Mandy L. Lanier, O.D. Maria B. Smith O.D.*

Welcome to Academy Eye Center! Please fill out the front and back of this form entirely.

**PATIENT INFORMATION**

**Today's Date:** \_\_\_\_\_

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Gender:  Male  Female

Marital Status:  Single  Married  Widow(er)  Separated  Other

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**PERSON RESPONSIBLE FOR THIS ACCOUNT**

Same as patient

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_

Please present your Medical and Vision Insurance card(s) to our reception staff!

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Last seen: \_\_\_\_\_

## OCULAR HISTORY

Do you wear glasses?  yes  no If so, how long? \_\_\_\_\_

Do you wear contacts?  yes  no If so, how long? \_\_\_\_\_  soft  rigid  disposable

Do you sleep in your contacts?  yes  no What solution do you use? \_\_\_\_\_

**Eye Diseases:** Do you now, or have you ever had, any of the following?

- Cataract  Glaucoma  Detached Retina  Diabetic eye disease  Macular Degeneration   
Lazy Eye  Eye Injury  Other

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**Eye Surgeries:** Please list any surgeries that you have had on your eyes or eyelids.

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**Family Eye History:** Have your grandparents, parents, siblings or children had any of the following?

- Cataract  Glaucoma  Detached Retina  Diabetic eye disease  Macular Degeneration   
Lazy Eye  Eye Injury  Other

**Eye Medications:** Please list any medications (including non-prescription) that you use for your eyes.

Medication	Eye	Frequency	Medication	Eye	Frequency
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\_\_\_\_\_

## PATIENT MEDICAL INFORMATION

Do you currently or have you ever had any of the following?

yes no

yes no

- |                          |                          |                                   |                          |                          |                                    |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever/ Weight Loss                | <input type="checkbox"/> | <input type="checkbox"/> | Joint/muscle pain                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Ears/mouth/nose/throat            | <input type="checkbox"/> | <input type="checkbox"/> | Skin Disease                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems                    | <input type="checkbox"/> | <input type="checkbox"/> | Headache                           |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure               | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/Other neurological diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression or psychiatric disease | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/fainting                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heart Beat              | <input type="checkbox"/> | <input type="checkbox"/> | Blood/bleeding disorders           |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina/Heart Attack               | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Other heart disease               | <input type="checkbox"/> | <input type="checkbox"/> | Seasonal allergies                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Emphysema                  | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Other lung disease                | <input type="checkbox"/> | <input type="checkbox"/> | Nursing                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes/thyroid                  | <input type="checkbox"/> | <input type="checkbox"/> | Other _____                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/intestinal problems       | <input type="checkbox"/> | <input type="checkbox"/> | Smoking                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney/urinary/genital disease    | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol consumption                |

**Medications:** Please list all medications including over-the-counter medications.

\_\_\_\_\_

**Allergies:** Please list any allergies: \_\_\_\_\_

**Family History:** Please list any health conditions that affect your grandparents, parents, siblings or children.

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