Welcome to the office of Dr. Joshua Meske and Dr. Robert Nyre.

Thank you for choosing our practice for your eye care needs. Please take a few minutes to answer the following questions so that we may better assist you with your health care needs.

Title: [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr. [ ] Other: ________ **Sex:** [ ] M [ ] F

First Name: ______________________ **Last Name:** ____________________ **Middle Initial:** ______

Preferred Name: ______________________ **Social Security #:** _________ - _________ - _________

Date of Birth: (MM/DD/YY) _____/_____/_____ **Mailing Address:** __________________________________

City: ____________________________________ **State**: ____________ **Zip Code:** ________________

Email: ____

Cell Phone: ________________________ **Texting:** Y/N **Home Phone:** __________________________

Primary Phone: [ ] Cell [ ] Home [ ] Work **Marital Status:** [ ] Single [ ] Married [ ] Other

Employment Status: [ ] Full-Time [ ] Part-Time [ ] Not Employed [ ] Retired [ ] Student [ ] Disabled

Work Phone: _________________________ **Employer:** _______________________________________

Race/Ethnicity: [ ] African [ ] Asian [ ] Caucasian [ ] American Indian/Alaskan Native

[ ] Native Hawaiian/Pacific Islander [ ] Hispanic/Latino [ ] Other: __________________

Emergency Contact: First Name: ______________________ Last Name: _________________________

Relationship to Patient: ____________________________ Phone: ______________________________

Parent /Guardian First Name: __________________ **Last Name:** ___________________ (If patient is a minor)

Who may we thank for referring you to our office? ____

………...

If you are using Tricare as your insurance, please fill out the portion below so that we can file your visit(s).

(If you are not filing with Tricare, please proceed to the next page.)

Sponsor First Name: ________________________ **Sponsor Last Name:** _________________________

Sponsor Middle Initial: _________ **Sponsor Social Security #:** _________ - _________ - _________

Sponsor Date of Birth: (MM/DD/YY) _____/_____/_____ **Relationship to Patient:** ____________________

Family Physician: ______________________________ **Town:** _____________________ **Diabetic:** Y/N

Date of Last Eye Exam: ______________ **with Dr.** _______________________ **Town:** ________________

Pharmacy: ________________ **Town:** ___________ **Currently using eye drops?** Y/N **Type?** __________

Do you wear Glasses? Y/N **Do you wear Contacts?** Y/N **If so, what brand?** _____________

Would you like to be fitted for contacts today? Y/N (Depending on insurance coverage, additional charges may apply.)

Reason for today's visit: ____

Have you or a family member experienced, or been treated for, any of the following? (Circle all that apply.)

AIDS/HIV:	N/A	Self	Father	Mother	Brother	Sister	Children
Allergies:	N/A	Self	Father	Mother	Brother	Sister	Children
Arthritis:	N/A	Self	Father	Mother	Brother	Sister	Children
Asthma:	N/A	Self	Father	Mother	Brother	Sister	Children
Blood/Lymph Disorder:	N/A	Self	Father	Mother	Brother	Sister	Children
Cancer:	N/A	Self	Father	Mother	Brother	Sister	Children
Diabetes:	N/A	Self	Father	Mother	Brother	Sister	Children
Ears, Nose, Throat Conditions:	N/A	Self	Father	Mother	Brother	Sister	Children
Gastrointestinal Conditions:	N/A	Self	Father	Mother	Brother	Sister	Children
Heart Disease:	N/A	Self	Father	Mother	Brother	Sister	Children
High Blood Pressure:	N/A	Self	Father	Mother	Brother	Sister	Children
High Cholesterol:	N/A	Self	Father	Mother	Brother	Sister	Children
Kidney Disease:	N/A	Self	Father	Mother	Brother	Sister	Children
Lupus:	N/A	Self	Father	Mother	Brother	Sister	Children
Neurological Conditions:	N/A	Self	Father	Mother	Brother	Sister	Children
Psychiatric Disorder:	N/A	Self	Father	Mother	Brother	Sister	Children
Seizures:	N/A	Self	Father	Mother	Brother	Sister	Children
Skin Conditions:	N/A	Self	Father	Mother	Brother	Sister	Children
Stroke:	N/A	Self	Father	Mother	Brother	Sister	Children
Thyroid Dysfunction:	N/A	Self	Father	Mother	Brother	Sister	Children

Height: ________________

Weight: ________________

Are you pregnant? Y/N

Are you nursing? Y/N

Do you smoke? Y/N

Have you ever smoked? Y/N

Do you use tobacco? Y/N

Do you drink alcohol? Y/N

Are you allergic to Latex? Y/N

Current Medications: (Prescription and over the counter. Please include dosages.)

____

Medication Drug Allergies:

____

Are you currently experiencing, or have experienced any of the following? (Circle all that apply.)

Blurry Vision: Near/Distance Burning Discharge Double Vision Dryness Excess Tearing/Watering

Eye Infection Eye Pain/Soreness Floaters/Spots Halos Headaches Itching Light Flashes

Light Sensitivity Redness Sandy/Gritty Feeling

Have you or a family member experienced, or been treated for, any of the following? (Circle all that apply.)

Cataracts:	N/A	Self	Father	Mother	Brother	Sister	Children
Eye Turn:	N/A	Self	Father	Mother	Brother	Sister	Children
Glaucoma:	N/A	Self	Father	Mother	Brother	Sister	Children
Lasik, RK, PRK:	N/A	Self	Father	Mother	Brother	Sister	Children
Lazy Eye:	N/A	Self	Father	Mother	Brother	Sister	Children
Macular Degeneration:	N/A	Self	Father	Mother	Brother	Sister	Children
Retinal Detachment:	N/A	Self	Father	Mother	Brother	Sister	Children