BACHO FAMILY EYE CARE LLC

Welcome To Our Office

For faster service, please complete the following form prior to arriving at our office.

Appointment Date: _____ Time: _____ Reason for Visit: _____

Last Name (please print): _____ First: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text: YES /NO

Email:___ ___

Birth Date: _____ M or F Employer/Occupation: _____

Marital Status: _____ SS #: _____ Race/Ethnicity: _____

Family Doctor: _____ Name of Practice: _____

Pharmacy: _____ Address: _____

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

I am currently being treated for medical conditions: YES / NO (Please list medications)

Disease:	Medication	Disease:	Medication
Diabetes:	_____	High Blood Pressure:	_____
Thyroid:	_____	High Cholesterol:	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergic to: _____

Personal Eye History: Surgery _____

___Glasses ___ Contacts ___ Cataracts ___ Glaucoma ___ Macular Degeneration ___ _____

Social History:

Do you Smoke? Yes / No Packs per day_____

Do you drink alcohol? Yes / No Drinks per day_____ per week _____ Social Only

Family History: F=Father M=Mother GF=Grandfather GM=Grandmother S=Sibling

___ Diabetes (Type 1/Type 2) ___ High Blood Pressure ___ Thyroid ___ High Cholesterol ___ _____

___ Cataracts ___ Glaucoma ___ Macular Degeneration ___ Lazy Eye ___ _____

How did you find our new office?_____ Referred by:_____