Palmer Family Eye Care

Gary Dietterick, O.D./ Daniel Klinger, OD
21 Corporate Dr • Easton, PA 18045
(610) 258-2442

Welcome To Our Office | PLEASE FILL OUT FORM IN IT'S ENTIRETY

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____

WorkPhone(_____

Social Security Number _____

Employer _____

Occupation _____

E-mail Address _____

Today's Date _____ How Long Since Last Exam~ _____

Previous Doctors name _____

D.O.B. _____ Age _____ Sex: M F

Medical Insurance _____

Vision Insurance _____

Martial Status: M W S D

Member Name _____ D.O.B. _____

Do you participate in a flex spending account? No Yes

How Did You Hear About Our Office?

Friend Relative? Who _____

Another Health Care Provider? Who? _____

Yellow Pages/Advertisement? Which Directory? _____

Participating Insurance Plan? _____

Other? _____

How Will You Settle Your Account Today? - *please circle*
Check Cash Credit Card

Medications: _____

Eye Medications: _____

Allergies (Drug or Environmental): _____

Family Doctor: _____

Personal Health History - *please circle*

Glasses	No	Yes
Contacts	No	Yes
Diabetes / Thyroid / Other Endocrine	No	Yes
Heart Problems / High Blood Pressure / Cholesterol	No	Yes
Other Vascular	No	Yes
Arthritis / Back Problems / Other Musculo-skeletal	No	Yes
Headaches / Migraines Syndrome / Other Neurological	No	Yes
Stomach /GI Problems / Hepatitis	No	Yes
HIV / AIDS / Shingles / Chicken Pox / Cold scores	No	Yes
Skin Cancer / Rashes / Other Skin	No	Yes
Hearing Loss / Balance Problems / Ear-Nose-Throat	No	Yes
Anemia / Leukemia / Bleeding Disorders	No	Yes
Smoking / Alcohol/Drug Use	No	Yes

Personal Ocular History - *please circle*

Glaucoma	No	Yes
Amblyopia / Lazy Eye	No	Yes
Macular Degeneration	No	Yes
Retinal Detachments	No	Yes
Other Retina	No	Yes
Cataracts	No	Yes
Corneal Problems	No	Yes
Dry Eye	No	Yes
Past Eye Injury/Surgery	No	Yes

Family History - *please circle*

Glaucoma	No	Yes
Amblyopia / Lazy Eye	No	Yes
Macular Degeneration	No	Yes
Retinal Detachments	No	Yes
Other Retina	No	Yes
Cataracts	No	Yes
Corneal Problems	No	Yes
Diabetes	No	Yes

Lifestyle Questions - *please circle*

Problems with glare or reflection?	No	Yes
Sensitivity to light?	No	Yes
Do you spend a lot of time outdoors	No	Yes
Do you work on computers for a long period of time?	No	Yes
Do you have more than 1 pair of current Rx glasses?	No	Yes
If you wear glasses, would you benefit form thinner, lighter glasses'	No	Yes
Are you interested in a "test drive" of the latest in contact designs?	No	Yes
Do you desire information regarding laser vision correction to decrease or eliminate your dependency on glasses?	No	Yes
Do your hobbies/ sports/ occupation require special protective eye wear?	No	Yes