NORWICH OPTOMETRY

Welcome & History Form

Name: _____DOB: _____

Occupation:_____

Employer:_____

E-Mail Address:_____

Home Telephone Number:_____

Cell Phone Number:_____Call_____Text_____

Prefered Phone Number: Cell_____ Home_____

Current Home Address:_____

Town_____State_____Zip Code_____

Do you wear contacts? Y / N Do you have any interest in wearing contacts? Y / N

Primary Care Doctor:_____Town:_____ Ph:_____

Pharmacy: _____Town:_____

Medications: _____

_____

Drug, Food or Seasonal Allergies:_____

Past Diagnosed Eye Conditions: _____

Social History: Alcohol Consumption Y / N If yes how many per day (avg). _____

Current Smoker Y / N / Quit If yes how much per day _____

Do you currently wear glasses? Y / N Age of current pair of glasses _____

Do you wear sunglasses? Y / N Hours per day on computer or smartphone_____

Please see other side ⇨

Family History: **Circle ALL That Apply**

None Apply Unknown Adopted

Heart Disease	Self	Father	Mother	Brother	Sister	Son	Daughter
High Cholesterol	Self	Father	Mother	Brother	Sister	Son	Daughter
Cancer	Self	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type I	Self	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type II	Self	Father	Mother	Brother	Sister	Son	Daughter
High Blood Pressure	Self	Father	Mother	Brother	Sister	Son	Daughter
Hyperthyroidism	Self	Father	Mother	Brother	Sister	Son	Daughter
Hypothyroidism	Self	Father	Mother	Brother	Sister	Son	Daughter
Amblyopia (lazy eye)	Self	Father	Mother	Brother	Sister	Son	Daughter
Cataracts	Self	Father	Mother	Brother	Sister	Son	Daughter
Macular Degeneration	Self	Father	Mother	Brother	Sister	Son	Daughter
Glaucoma	Self	Father	Mother	Brother	Sister	Son	Daughter
Retinal Detachment	Self	Father	Mother	Brother	Sister	Son	Daughter