# Family Eye Health & Contact Lens Center
# "Vision for a Lifetime"
# Dr. R. Mailhot, O.D.

Welcome to our office, thank you for choosing us for your eyecare needs. We appreciate the confidence you place in us. Please take a moment to complete the following information.

First Name _____ MI ____ Last Name _____ ☐Male ☐Female

Mailing Address _____ City _____ State ____ Zip_____

Date of Birth ____-____-_____ Social Security # ____-____-_____ Parent / Guardian _____

Day Phone# _____ Alternate# _____ Email _____

Current Occupation: _____ Employer / School_____ Race _____

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown ☐ Other _____

Height: ___ - ____Weight: _____Primary care doctor _____Pharmacy & Location_____

How were you referred to our office? ☐Friend/Relative _____ ☐Phone Book ☐Internet ☐Website

☐Sign out front ☐Healthcare Provider _____ ☐Other _____

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**Health / Eye History**

Were you referred by another Doctor or School? NO / Yes? Name _____

What is the main reason for today's exam? _____

Past Eye Surgeries ? No / Yes Year _____ Surgeon _____

Allergies to Medications: _____

Please List Prescribed Medications : Please provide List if you have one

_____

Do you smoke? O Never O Former OYes O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack

Hobbies / Interests: _____

**Eyeglass History**

How many sets of glasses do you own? _____ What special purposes do you wear them?_____

**Contact Lens History**

Current contact lens wearer? _____ Former wearer _____ Never tried Contacts _____

**PLEASE RETURN FORMS TO THE RECEPTIONIST ONCE COMPLETED**

**THANK YOU**