Dr. Meade H. Kendrick, III
and Associates
Optometrists

eye spectrum®
OPTICAL BOUTIQUE

Welcome to our office! The following information is for our records. Please fill out as completely as possible.
If you have any questions, please ask our receptionist for assistance.

Patient _____ Age _____ Date of Birth _____

What first name do you go by? _____ Cell Phone _____

Email _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Employer _____ Telephone _____

Business Address _____ State _____ Zip _____

Occupation _____

Spouse or Parents _____

Employer _____ Telephone _____

Referred By _____ Address _____

INSURANCE INFORMATION

Insurance Company _____ Telephone _____

Group Number _____ Social Security Number _____

MEDICAL HISTORY

	Yes	No
Diabetes	❑	❑
High blood pressure	❑	❑
Recent surgery	❑	❑
Severe headaches	❑	❑
Sinus trouble	❑	❑
Thyroid disorders	❑	❑
Allergies	❑	❑

Drug allergies (please list)

_____

_____

_____

Taking medications (please list)

_____

_____

_____

_____

_____

PERSONAL EYE HISTORY

	Yes	No
Glaucoma	❑	❑
Sensitive to light	❑	❑
Eye surgery	❑	❑
Cataracts	❑	❑
Frequent red eyes	❑	❑
Trouble seeing up close	❑	❑
Dry eyes	❑	❑
Double vision	❑	❑
Trouble seeing at night	❑	❑
Trouble seeing at distance	❑	❑
Floaters	❑	❑

Other:

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

	Yes	No
Glaucoma	❑	❑
Cataracts	❑	❑
Eye disease	❑	❑
Blindness	❑	❑
Crossed eyes	❑	❑
High blood pressure	❑	❑

Diabetes (If so, who?) _____

_____

LIFE-STYLE INFORMATION

	Yes	No
Computer work	❑	❑
Close work	❑	❑
Outside work	❑	❑
Driving	❑	❑

Other:

_____

_____

_____