VINCENT R. VICCI Jr., O.D., P.A. D.P.N.A.P.

Patient Information

Today's Date:____________________

Patient's Name:____M____F____

Address:____

Town:____________________State:________________Zip:____________________

Telephone: Home: (   )____________Work: (   )____________Cell: (   )____________

Email:____

Date of Birth:________________________SS#:________________________

Race:__________________Ethnicity:________________Preferred Language:____________

Marital Status: __________Spouse's Name: ____________________ Phone #:____________

Mother's Name (If Minor)__________________________Email:____________________

Father's Name (If Minor)__________________________Email:____________________

Communication Preference: □ Home # □ Work # □ Cell # □ Email:____________________

Pharmacy Name: ________________________ Phone/Fax:________________________

PATIENTS OCCUPATION OR/SCHOOL:

School Name:________________________________Grade:____________

Address:________________________________Phone #:____________

Employer Name:______________________________Phone #:____________

Address:____

Reason for today's visit:______________________________

How you were referred to Dr. Vicci:______________________________

Did you ever wear glasses?____________For how long?________________________

Do you wear contact lenses?____________For how long? ____________Type:____________

PRIMARY CARE PHYSICIAN:________________Phone Number:__________ Fax:__________

Can we forward your records to them if requested? ________________________

OCULAR HISTORY:

Does your vision blur for any of the following: Driving____________Chalkboard____________

Watching Movies__________Computer/TV____________Close work or reading____________

Do your eyes: Ache__________ Burn__________ Tire__________ Water__________

Do you have headaches?________________For how long? ________________________

Location________________________Frequency________________________

Sharp__________ Dull__________ Severe______________ Mild______________

When do they occur (what time of day/how often?)________________________

How do you treat these headaches?________________________________

Do bright lights bother your eyes?____________Do you ever see things double?____________

Have you had any injuries to your head or face?________________________

Have you had any surgery? ________________________________