Hosea J. Soileau, Jr., OD, Inc.
221 West Cotton St.
Ville Platte, LA 70586
(337)363-7200 Fax: (337)363-4827

Dr/Mr/Miss/Mrs/Ms ____ **Today's Date**_____/_____/_____
(Print Patient Information) Last First MI

Mailing Address ____________________________________**City**____________________ **St**_______ **Zip** ________

Home Phone ____________ **Work Phone**______________ **Cell Phone** _____________**Date of Birth** ___________ **Age**_____

Employer (or School)______________________________ **Occupation (or Grade)** ______________________________

Sex M F Social Security #: ____-____-_______ **Insurance (1st)** ____

(circle one) Married Single Widowed **Insurance (2nd)** ____

Spouse or Parents Name:____ **Work Phone** ____________________

Date of Last Eye Exam: _________________ **Dr's Name:** ____

Main Hobbies: ____

Family Doctor or Personal Physician: ____

Whom may we thank for referring you to our office? ____

Or how did you learn about our office? ____

Any problems with present contact lenses or glasses? ____

PERSONAL MEDICAL HISTORY		
Allergies	No	Yes
Asthma	No	Yes
Skin Disorder	No	Yes
Eye Disease	No	Yes
Eye Injury	No	Yes
Eye Surgery	No	Yes
Lazy Eye	No	Yes
Cataract	No	Yes
Glaucoma	No	Yes
Arthritis	No	Yes
Cancer	No	Yes
Diabetes	No	Yes
Heart Disease	No	Yes
High Blood Pressure	No	Yes
Kidney	No	Yes
Stroke	No	Yes
Other ______________	No	Yes

FAMILY MEDICAL HISTORY			Relationship
Macular Degeneration	No	Yes	____________________
Blindness	No	Yes	____________________
Cataracts	No	Yes	____________________
Glaucoma	No	Yes	____________________
Diabetes	No	Yes	____________________
Heart Disease	No	Yes	____________________
Stroke	No	Yes	____________________
Cancer	No	Yes	____________________
HBP	No	Yes	____________________
Other ___________	No	Yes	____________________

MEDICATIONS (Rx/Over the Counter)			Name of Medication
Antihistamines (Allergy)	No	Yes	____________________
Diuretics ("water pills")	No	Yes	____________________
High Blood Pressure Pills	No	Yes	____________________
Oral Contraceptives	No	Yes	____________________
Eye Drops	No	Yes	____________________

ALLERGIES To Medications: ____

Do you use cigarette/tobacco: No Yes: (amt) _____ **Alcohol: No Yes: (amt)** ______ **Other Substance? No Yes** ___________

Do you have or see any of the following?

Burning	Gritty Sensation	Spots	Tearing
Redness	Itchy Sensation	Floaters	Double Vision
Dryness	Sensitivity to Light	Blurred Vision	Headaches
Night Blindness	Flashes of Light	Dizziness	Mucous

Other: ____

Are you interested in contact lenses? **No** **Yes**
What kind? Daily Wear Soft Gas Permeable Extended Wear
Colored Disposable Bifocal

Are you interested in new glasses? **No** **Yes**
What kind? Extra pair Prescription Sunglasses Readers

OFFICE ONLY: ROS Update

________________ ________________