Welcome to the office of
Douglas J. Kelley, O.D.

Patient's Name_____Date_____.

Address_____Date Of Birth_____.

City_____State_____Zip Code_____.

Home Phone_____Work Phone_____Cell_____.

Employer_____Occupation_____FT, PT, Retired

E-Mail Address(Optional)_____ Male / Female

Marital Status: Single, Married, Other Social Security # _____.

May we thank anyone for referring you to this office?_____.

Vision Insurance

Will you be using any vision insurance? Yes____ No____.

If so what type?_____Thru what employer?_____.

Subscriber's name_____Their S.S. #_____.

Subscriber's birthdate_____Relation to patient_____.

Ocular History

Do you wear glasses? Yes___ No___ Contact Lenses? Yes___ No___.

Have you had an eye injury, disease, or operation?_____.

Primary reason for today's visit?_____Last eye exam?_____.

Have you ever been diagnosed with cataracts? Yes____No____ Glaucoma? Yes____ No_____.

Medical History

High blood pressure? Yes____No___ Lung problems? Yes____ No____.

Diabetes? Yes____ No_____ Allergies? Yes____ No____.

Thyroid problems? Yes____ No____ Headaches? Yes____ No____.

Please list any medications you are currently taking_____.
_____.