

**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 \_\_\_\_\_.

\_\_\_\_\_.