Patient Record

111 Retreat St., Westminster, SC 29693 • 864-647-5076 Fax 864-647-0828
1390 Tiger Blvd., Suite 102, Clemson, SC 29631 • 864-654-4141 Fax 864-654-4144

WESTMINSTER VISION ASSOCIATES

Name: _____ Date of Birth: _____ Date: _____
Occupation: _____
Phone (H): _____ Phone (W): _____ SSN: _ _ _ - _ _ - _ _ _ _
Have you had an exam here before: ☐ YES ☐ NO When? _____
Address: _____ City: _____ State: _____Zip: _____
Email: _____
Vision Insurance: _____ Medical Insurance: _____
How do you identify your Race/Ethnicity? *(You have the option to decline this question.)*
☐ African American/Black ☐ Caucasian/White ☐ Hispanic/Latino ☐ Asian ☐ Other/Mixed ☐ Hawaiian/Pacific Islander
☐ American Indian/Alaska Native Preferred Language:_____
Do you currently wear glasses? ☐ YES ☐ NO Do you smoke? ☐ Yes ☐ No How much?_____
Do you wear contact lenses? ☐ YES ☐ NO Do you drink? ☐ Yes ☐ No How often? _____
What is the main reason for your visit? Please check one:
☐ Checkup/Exam ☐ Office Visit ☐ Poor Vision ☐ Glaucoma Check ☐ Can't Pass Driver's Test
☐ Other: _____
List any medications you take, and what they are for:_____
_____
List any medicines / substances to which you have an allergy:_____
_____
Do you have a family history of? ☐ Diabetes ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Detachment
☐ High Blood Pressure ☐ Cataracts ☐ Other Eye Problems:_____
Do you / Have you had? ☐ Dry Eyes ☐ Eye Surgery ☐ Eye Injury ☐Blurred Vision ☐ Glaucoma
☐ Macular Degeneration ☐ Other Eye Problems: _____

Party/Guardian: _____ Date of Birth: _____ SSN: _ _ _ - _ _ - _ _ _ _