



Welcome back to Blue Ridge Eye Associates!



Patient Name: (Mr Mrs Ms Miss Dr) \_\_\_\_\_ Date: \_\_\_\_\_

Have you had any change in your home/email address or phone number? If so, please list:

**Today's Appointment**

Briefly, what is the main reason that you came into the office today?

Are you interested in a contact lens fitting today?  Yes  No

**Recent Physical Exam**

Date of last physical examination: \_\_\_\_\_ By whom: \_\_\_\_\_

**Patient Symptoms**

Do you experience any of the following symptoms? **Circle any/all that apply**  
Blurred vision      Eye redness      Jaw pain      Stuffy nose  
Eye pain      Loss of vision      Rash      Shortness of breath  
Tearing      Flashes/Floaters      Fever      Headache

**Patient/Family History**

Have you or anyone in your family ever had any of the following conditions?  
**Circle S for Self and/or F for Family for all that apply**  
**S F** Macular degeneration      **S F** High blood pressure      **S F** Stroke  
**S F** Glaucoma      **S F** Thyroid abnormalities      **S F** Bleeding disorders  
**S F** Diabetes      **S F** Arthritis      **S F** Other

**Medications/Allergies**

Are you taking any medications?  Yes  No  
If yes, do you allow Blue Ridge Eye Associates to retrieve prescriptions online?  Yes  No  
Do you have any medical allergies?  Yes  No If yes, please list:

Fees are due upon services rendered. Please select your preferred method of payment:  
 Cash  Check  Debit Card  Medicare  Discover  Master Card  Visa

For out-of-network vision plans, we'll submit claims on your behalf for reimbursement directly to you.

**We appreciate the opportunity to continue serving your visual needs**



**BLUE RIDGE EYE ASSOCIATES**

**Sara Harter, OD, MPH**

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