DRS. ODOM, COBURN & RICHARDSON
WELCOME TO OUR OFFICE

Last Name _____ Sex M / F Date ___/___/___

First Name _____ Date of Birth ___/___/___ Age ____

Address _____ Social Security # ____ - ___ - ____

City _____ State ____ Zip _____

Home Phone _____ Employer _____
Daytime Phone _____ Occupation _____
Cell Phone _____

Email address _____

(circle one) Married Single Child Widowed Spouse's name _____
If minor, Name of Guarantor _____

Preferred Language _____ Race _____ Ethnicity _____

Glasses History: None Part time Full time Distance Near

Contact Lens History: None Soft Disposable: Daily ___ Weekly ___ Monthly ___
Daily Wear Overnight Astigmatism Monovision Gas Permeable
Brand/Prescription currently wearing _____

Past Eye Surgery: Cataract Glaucoma Eye Muscle Cornea Transplant Trauma

Social History: Tobacco: Former Smoker Y / N Current Smoker: Light / Average / Heavy
Alcohol: None / Social / 1-2 Daily / 3+ Daily
HIV/AIDS Y / N Blood Transfusion Y / N Narcotic Use Y / N

Height: _____ ft. _____ in. **Weight:** _____ lbs.

Family History: (circle any that apply and give relationship to patient)

Lazy Eye _____
Blindness _____
Cataracts _____
Glaucoma _____

Keratoconus _____
Retinal Detachment _____
Macular Degeneration _____
Other _____