Littlefield Eye Associates
7400 WORNALL RD
KANSAS CITY, MO 64114

Patient Form

Complete and submit this form before your appointment.

Basic Information

First Name | MI | Last Name | Sex ( ) Male ( ) Female

Date of Birth | Age 0 | Marital Status | SSN Last 4

Street Address/PO Box | City | State | Zip

Employment Status | Occupation | Allow Messaging ☑ Home ☑ Text ☑ Email

Home Phone | Cell Phone | Email Address

Employer Info

Employer Name | Phone

Street Address/PO Box | City | State | Zip

Other Contact Info

Person responsible for charges | Relationship to Patient | Phone

Emergency contact | Emergency contact relationship | Phone

Visit Information

Last eye exam date | First Visit ( ) Yes ( ) No

Reason for current visit | Referred by

Eye Health *Check all that apply*

- [ ] Amblyopia
- [ ] Blurred Vision - Far
- [ ] Blurred Vision - Near

- [ ] Burning Eyes
- [ ] Cataracts
- [ ] Double/Distorted Vision
- [ ] Drooping Eyelid
- [ ] Dry Eyes
- [ ] Eye Surgeries
- [ ] Eye Turn
- [ ] Floaters/Spots
- [ ] Fluctuating Vision
- [ ] Foreign Body Sensation
- [ ] Glaucoma
- [ ] Glare/Light Sensitivity
- [ ] Headaches
- [ ] Itchy Feeling
- [ ] Infection of eye/lid
- [ ] Loss of Vision - Central
- [ ] Loss of Vision - Side
- [ ] Mucus/Discharge
- [ ] Redness
- [ ] Retinal Detachment
- [ ] Tearing/Watery Eyes

General Health *Check all that apply*

- [ ] Allergies/Hay Fever
- [ ] Asthma/Respiratory
- [ ] Blood Disorders
- [ ] Cancer
- [ ] Cardiovascular/High BP
- [ ] Chronic Bronchitis
- [ ] Chronic Cough
- [ ] Diabetes
- [ ] Emphysema
- [ ] Gastrointestinal Problems
- [ ] Heart Attack/Strokes
- [ ] Headaches/Migraines
- [ ] Kidney Disease
- [ ] Psychiatric Depression
- [ ] Rheumatoid Arthritis
- [ ] Thyroid/Endocrine Disease
- [ ] Skin Disorders
- [ ] Weight Loss/Gain

Do you smoke tobacco products?

- ( ) Yes, I smoke everyday
- ( ) Yes, I smoke occasionally
- ( ) No, I'm a former smoker
- ( ) No, I've never been a smoker

Family History - Blood Relatives *Check all that apply*

- [ ] Amblyopia
- [ ] Blurred Vision - Far
- [ ] Blurred Vision - Near
- [ ] Burning Eyes
- [ ] Cataracts
- [ ] Double/Distorted Vision
- [ ] Drooping Eyelid
- [ ] Dry Eyes
- [ ] Eye Surgeries
- [ ] Eye Turn
- [ ] Floaters/Spots
- [ ] Fluctuating Vision
- [ ] Foreign Body Sensation
- [ ] Glaucoma
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- [ ] Headaches
- [ ] Itchy Feeling
- [ ] Infection of eye/lid
- [ ] Loss of Vision - Central
- [ ] Loss of Vision - Side
- [ ] Mucus/Discharge
- [ ] Redness
- [ ] Retinal Detachment
- [ ] Tearing/Watery Eyes

Physician / General Practitioner

Physician Name	Phone	Last Medical Exam Date

Medications *Enter all medications taken, and for which condition each is taken*

	Medication	Condition
1		
2		
3		
4		
5		
6		
7		
8		

Allergies

Enter all medications or substances to which the patient is allergic

Please answer the following questions

Are you pregnant or nursing?

- Yes
- No

Do you have trouble driving at night?

- Yes
- No

Do you wear glasses?

- Yes
- No

Do you wear contacts?

- Yes
- No

Do you experience blur, headaches, or eyestrain with computer use?

- Yes
- No

Are you interested in laser (refractive) surgery to correct your vision?

- Yes
- No

Vision Insurance Information

Insurance Company

ID Number

Group Number

Patient's relationship to insured

- Self
- Spouse
- Child
- Other

Primary Insured's Sex

- Male
- Female

Name of the Insured

Insured's Phone Number

Insured's Date Of Birth

Other Insurance Information

Insurance Company

ID Number

Group Number

Patient's relationship to insured

- Self
- Spouse
- Child
- Other

2nd Insured's Sex

- Male
- Female

Name of the Insured

Insured's Phone Number

Insured's Date Of Birth

Additional Comments

Is there anything else we should know? Let us know below.