Classic Vision

1141 36th Ave. NW Norman, OK 73072 (405) 447-5001
905 N Main St. Noble, OK 73068 (405) 872-0500

Date: _____/_____/_____ Name: _____

DOB:_____/_____/_____ Marital Status: S M W D **Sex:** M F **Social Security: _____**

Address:_____ City:_____

State:_____ Zip:_____ Home Phone: _____ Cell Phone: _____

Email Address:_____

Employer:_____ Occupation:_____

Medical Insurance:_____ Vision Insurance:_____

Name of Responsible Party:_____

Medical History:
Name of current physician: _____ Date of last physical exam:_____/_____/_____
How would you rate your current health? Excellent Good Fair Poor
Current Medications:_____
_____
Are you allergic to any medications? Yes No If so, please list:_____
Do you use tobacco? YES NO Do you use alcohol? YES NO
Are you pregnant? YES NO Are you nursing? YES NO

Do you have any problems with these systems? (Please circle YES or NO)
Gastrointestinal: YES NO **Neurological:** YES NO **Endocrine:** YES NO **Ears/Nose/Throat**: YES NO
Urinary: YES NO **Blood/Lymph:** YES NO **Cardiovascular:** YES NO **Allergic/Immunologic:** YES NO
Muscle/Bone: YES NO **Respiratory:** YES NO Skin: YES NO **Headaches:** YES NO Mental: YES NO
High blood pressure: YES NO Eyes: YES NO **Diabetes:** YES NO If answered yes, what type? _____
Other:_____ Ocular surgeries:_____

Family History:
High Blood Pressure: YES NO Relation:_____ **Macular Degeneration**: YES NO Relation:_____
Diabetes: YES NO Relation:_____ **Retinal Detachment:** YES NO Relation:_____
Glaucoma: YES NO Relation:_____ **Cataracts**: YES NO Relation:_____

Personal Eye Information:
Do you have any eye conditions or problems? YES NO What Kind?_____
Do you wear glasses? YES NO Do you wear contacts? YES NO What Kind?_____
Are you interested in wearing contacts? YES NO What hobbies do you participate in?_____
How did you hear about us?_____

If you receive a complete pair of glasses from us and for some reason are not completely satisfied with your order, the charge for the lenses is non-refundable as these are custom made to your specific prescription and measurements. Lab fees apply and are subject to change.

Signature of patient or guardian:_____Date:_____/_____/_____