



DR. MARY ANNE C. MURPHY, O.D.
5760 WEST 120TH AVENUE, SUITE 240
BROOMFIELD, CO 80020

Name: _____ Date: ____/____/____

Change in Address

Street Address: _____ City: _____ State: ____ ZIP: _____

Change in Phone Number

Home Phone (____) _____ Cell Phone (____) _____ Work Phone: (____) _____

Change in Vision Insurance (*Please present copy of card or we will be unable to bill on your behalf.*)

VSP EyeMed Vision Insurance is through Medical Insurance Other _____

Change in Medical Insurance (*Please present copy of card or we will be unable to bill on your behalf.*)

United Health Care Medicare Kaiser Rocky Mountain Health
 Cigna TriCare Aetna
 BC/BS/Anthem Sloans Lake Great West Other _____

Change in Eye History

Do you experience any of the following?

<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Tired Eyes	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Glare/Excess Light	<input type="checkbox"/> Distorted Vision/ Halos
<input type="checkbox"/> Sandy/Gritty Eyes	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sensitivity	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Burning	<input type="checkbox"/> Red Eyes	<input type="checkbox"/> Floaters in Vision	
<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Excess Tearing/ Watering	<input type="checkbox"/> Loss of Vision	

Are you interested in LASER refractive surgery? Yes No

Do you work on a computer? Yes No If yes, how many hours per day? ____ Distance between eyes & monitor ____

Change in Medical History - Please indicate any **NEW** problems since your last exam.

Ear/Nose/Throat	<input type="checkbox"/>	Musculoskeletal	<input type="checkbox"/>
Cardiovascular	<input type="checkbox"/>	Neurological	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	Lymphatic/ Hematologic	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	Endocrine	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>		

Please explain any YES answers: _____

Hobbies

<input type="checkbox"/> Computer Use	<input type="checkbox"/> Running	<input type="checkbox"/> Basketball	<input type="checkbox"/> Hunting
<input type="checkbox"/> Skiing/ Boarding	<input type="checkbox"/> Fishing	<input type="checkbox"/> Volleyball	<input type="checkbox"/> Motorcycling
<input type="checkbox"/> Racquet Sports	<input type="checkbox"/> Woodwork	<input type="checkbox"/> Hiking	<input type="checkbox"/> Golf