Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form, If you have any questions or concerns, do not hesitate to ask for assistance.

Name _____

Address_____ City & State _____ Zip_____

Birthdate_____ Home phone #_____ Cell #_____Email_____

Are You: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Occupation: _____Employer_____

Spouse or parent's name_____ Birthdate_____ SS#_____

If you are a student, name of school/college_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency_____Phone #_____

Insurance Information:

Name of insured_____ Birthdate_____ Social Security #_____

Relationship to patient_____

Insurance Co._____ Insurance card #_____

Secondary Insurance: Insurance Co._____ Insurance card #_____

Health History:

Primary Care Doctor_____ Phone #_____

Reason for today's exam_____

Date of last eye exam_____ Name of Eye Doctor _____

Are you currently being treated for the following?

High Blood Pressur☐ Diabete☐ Heart Disease☐ Stroke☐ Arthritis☐ Other _____

If applicable, are you pregnant or nursing? _____ (may limit certain aspects of exam)

SURGERY: Have you had any previous eye surgery, laser eye surgery or eye injury?

If yes, please give name(s) of operation(s) or injuries and date(s): _____

_____

What non-ocular operations or hospitalizations have you had? Please give type(s) and date(s): _____

_____

Do you smoke? _____ Former smoker? _____ Do you Drink Alcohol? _____

Have you ever had any of the following? (Circle all that apply)

Glaucoma☐ Macular degeneration☐ Cataracts☐ Retinal tear or detachmen☐ Halos☐

Severe Pain☐ Sensitivity to light☐ Eye infection or disease☐ Floaters or dark spots☐ Redness Dryness Discharge☐

Lazy eye☐ Double vision☐ Blurred visio☐ Eye strain☐ Eyes burn, itch or water☐

Crusting on lids Drooping lid☐ Sandy/Gritty feeling☐ Other? _____

Over ->

Review of Systems:

Heart (chest pain, angina, irregular heartbeat) _____

Respiratory (cough, wheezing, shortness of breath, asthma) _____

Ear/Nose/Throat (sore throat, sinus, earache, hearing loss) _____

Gastrointestinal (abdominal pain, heartburn, bowel problem, vomiting) _____

Urinary (pain when urinating, blood in urine) _____

Hematological/Lymphatic (blood disorders, bruising, cuts heal slowly, enlarged glands) _____

Endocrine (thyroid)_____

Integumentary (rashes, dry skin) _____

Musculoskeletal (joint pain, stiffness and swelling, muscle pain and weakness) _____

Neurological (numbness, headache, seizures, paralysis) _____

Psychiatric (depression, anxiety, insomnia, confusion) _____

FAMILY HISTORY: **Please include which blood relatives have/had any of the following:**

1. Glaucoma
   ◉ No ○ Yes _____
2. Macular degeneration
   ◉ No ○ Yes _____
3. Retinal Detachment
   ◉ No ○ Yes _____
4. Cataract
   ◉ No ○ Yes _____
5. Other Eye Conditions _____
   _____

ALLERGIES to Medications, foods, chemicals, environmental. Please include Ocular allergies. (Please describe reaction and when it occurred.)_____

_____

PHARMACY:

_____

PRESCRIPTION & OVER THE COUNTER

_____

_____

When do you wear your glasses?

☐ All the time ☐ Reading/near work ☐ Work Safety ☐ Distance tasks only

☐ Computer work Other, please explain_____

Have you ever worn contacts? _____Do you work at a computer or video display terminal? _____

What hobbies or sports do you participate in? _____

MEDICATIONS include Ocular and Non-Ocular: (give name, dosage, frequency)

Signature of Patient or Guardian **Date**

_____

Do you have a health care proxy? If so please let us know