EYECARE PROFESSIONALS

Todays Date: _____

Welcome to our office!

Patient's Full Name _____ Nickname_____
D.O.B._____SS#_____ Phone#_____or _____
Texting OK? Yes / No Email_____ COVID Vaccine? Yes / No -Pfizer/Moderna/ J&J
Address_____ City _____State_____ Zip_____
Marital Status_____Employment Status FT/ PT/ RET Occupation_____
Insurance Company / Policy no._____
Policy Holders Name, D.O.B, & SS# _____

Reason for Today's Visit: check all that apply

❑ Treatment of Eye Disease ❑ Updating Glasses
❑ Emergency Office Visit ❑ Contact lenses
❑ Referred by Physician ❑ Other_____

Do you wear glasses? ❑ Yes ❑ No
If yes, are they for: ❑ Reading ❑ Distance ❑ Both
Do you wear contact lenses? ❑ Yes ❑ No
If yes, what type of contacts?_____

Eye History

Date of last eye exam & eye doctor:

_____

Do You Have a History of:	No	Yes: Self	Family: Who
Cataracts	❑	❑	❑ _____
Glaucoma	❑	❑	❑ _____
Floaters	❑	❑	❑ _____
Lazy Eye (Amblyopia)	❑	❑	❑ _____
Crossed Eyes	❑	❑	❑ _____
Eye Injury	❑	❑	❑ _____
Eye Surgery	❑	❑	❑ _____
Retinal/Macular Disease	❑	❑	❑ _____
Retinal Detachment	❑	❑	❑ _____
Color Blindness	❑	❑	❑ _____
Vision Loss	❑	❑	❑ _____
Dry Eye Issues	❑	❑	❑ _____
Other Eye Problems	❑	❑	❑ _____

Medical History

Date of last medical exam & medical doctor:

_____

Do You Have Problems with:	No	Yes
Endocrine (diabetes, thyroid)	❑	❑
Cardiovascular (highBP,heart, cholesterol)	❑	❑
Respiratory (lung disease)	❑	❑
Ear, Nose or Throat	❑	❑
Allergies / Immunologic	❑	❑
Neurological (headaches, seizures)	❑	❑
Gastrointestinal (stomach, bowel)	❑	❑
Muscles, Bones, Joints	❑	❑
Blood / Bleeding Disorder	❑	❑
Skin (acne, rosacea, rash)	❑	❑
Psychiatric (anxiety, depression)	❑	❑
Constitution (fever, fatigue, weight change)	❑	❑

Please list all Medications and Eyedrops that you are currently taking: (including non-prescription)

_____ _____ _____

Are you allergic to any medications or eye drops? _____

Family History

Has any member of your family had these diseases and who? (Circle all that apply)

Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Arthritis, Other heritable disease:_____

_____

Social History

Does your vision limit any of your activities? ..YES NO If YES, which activities? _____
Do you drink alcohol?.....YES NO If YES, how much?_____
Do you smoke or former smoker?.....YES NO If YES, how much/ quit when?_____
Have you ever had a blood transfusion?.....YES NO If YES, when?_____