EYECARE PROFESSIONALS

Welcome to our office!

Patient's Full Name _____ Date _____
I prefer to be addressed as _____ Date of Birth _____ SS# _____
Address _____ City _____ State _____ Zip _____
Phone-Home _____ Work _____ Cell _____ Email _____
Occupation _____ Texting OK? Yes___ No___ Contact me by _____
Employment Status FT/ PT/ RET Marital Status _____ Head of Household _____
Marital Status _____ Insurance Company / Policy no. _____
Policy Holder's Name _____ Date of Birth _____ SS# _____
Please tell us how you heard about our office:

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: _____
Last 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	☐	☐	☐ _____
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 now 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? _____

Please continue on the other side