Family EyeCare
exceptional eye care

WELCOME TO OUR OFFICE

Name: ______________________

Street ______________________

City ______________ State______ Zip__________

Home Phone ______________ Work Phone______________

Employer or School ______________________

Occupation ______________________

Social Security # ______________________

Vision Insurance ______________________

ID# ______________________

Health Insurance ______________________

ID# ______________________

Medicare # ______________________

Medicaid # ______________________

Current Medications (Rx or Over the Counter)

			Name of Medication
Antihistamines	☐Yes	☐No	____________
Diuretics (fluid pills)	☐Yes	☐No	____________
Blood Pressure Pills	☐Yes	☐No	____________
Oral Contraceptives	☐Yes	☐No	____________
Sleeping Tablets	☐Yes	☐No	____________
Diabetic Medications	☐Yes	☐No	____________
Heart Medications	☐Yes	☐No	____________
Eye Drops	☐Yes	☐No	____________
Other	☐Yes	☐No	____________

Allergies:______________________

If you have a list of medications, please attach.

Pharmacy Used:______________________

Family Medical History

			Relationship
Blindness	☐Yes	☐No	____________
Cataracts	☐Yes	☐No	____________
Glaucoma	☐Yes	☐No	____________
Diabetes	☐Yes	☐No	____________
Heart Disease	☐Yes	☐No	____________
Macular Degeneration	☐Yes	☐No	____________
Retinal Detachment	☐ Yes	☐ No	____________
High Blood Pressure	☐Yes	☐No	____________
Crossed Eyes	☐Yes	☐No	____________
Arthritis	☐Yes	☐No	____________
Cancer	☐Yes	☐No	____________
Thyroid Disease	☐Yes	☐No	____________
Lupus	☐Yes	☐No	____________

Other______________________

Today's Date______________ Date of Last Exam____________

Date of Birth____________ Age________ Sex M___F___

What is the major purpose of this visit?__________________

Spouse (or Parent's Name) ______________________

E-mail____________________ Cell Phone____________

May we use your email to contact you about appointments or notify you about special offers? ___Yes ___No

Do you....

...Work at a computer for long periods?	☐Yes	☐No
...Have more than one pair of glasses?	☐Yes	☐No
...Want information on thinner, lighter lenses?	☐Yes	☐No
...Wear Bifocals?	☐Yes	☐No
...(If yes, are you bothered by head tilting, restricted areas of vision correction, etc.)	☐Yes	☐No
...Spend time outdoors? (How much)	☐Yes _____Hrs/week	☐No
...Have prescription sunglasses?	☐Yes	☐No
...Have problems with glare or reflection	☐Yes	☐No
particularly when driving at night?	☐Yes	☐No
...Have you ever worn/are currently wearing contacts?	☐Yes	☐No
Are you planning on getting new contacts today?	☐Yes	☐No
Are you planning on getting new glasses today?	☐Yes	☐No

SOCIAL HISTORY

☐ I wish to discuss my social history with the doctor. (Check box)

Do you use tobacco products?	☐Yes	☐No
Do you use alcohol?	☐Yes	☐No
Do you use illegal drugs?	☐Yes	☐No

Have you ever been exposed to or infected with:
☐Hepatitis ☐HIV ☐Gonorrhea ☐Syphilis

How did you first hear about our office?

- ☐ Friend or Relative Who? ______________
- ☐ Another Health Care Practitioner Who? ______________
- ☐ Internet/Webpage
- ☐ Newspaper Advertisement ☐Radio Advertisement
- ☐ Yellow Pages Which Directory______________
- ☐ Civic Group or Community Event Which? ______________
- ☐ Previous Patient Who? ______________
- ☐ Other______________

Please turn form over and complete side two

PLEASE CHECK YES OR NO ON ALL **Primary Doctor's Name**___________________

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

SYSTEM	YES	NO	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eyes	☐	☐	☐
Sites of Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

SYSTEM	YES	NO	?
EARS, NOSE, MOUTH, THROAT			
Allergies, Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary	☐	☐	☐
Gentials/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
ARE YOU PREGNANT?	☐	☐	

If you answered YES to any of the above or have a condition not listed, please explain.

____

______________________________ **Doctor Signature**

______________ **Date**

Date	Tech Int.	Patient History Changes	Dr. Initials
_____	_______	________________________________	________
_____	_______	________________________________	________
_____	_______	________________________________	________
_____	_______	________________________________	________