PATIENT INFORMATION

Patient Name _____ Date: _____

SSN _____ ☐ Male ☐ Female Birthdate _____ Home Phone _____ Cell Phone _____

Mailing Address _____ Email Address _____

City _____ State _____ Zip _____

Occupation _____ Employer _____ Work Phone _____

Spouse _____ Parents (if under 18) _____

If patient is a student, name of school/college _____ Grade _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Primary Care Physician _____ Phone _____

Eye History

Have you ever had the following eye conditions? (Circle "no" or "yes", leave blank if uncertain) **Explanation**

Glaucoma, Cataracts, Etc.	No	Yes
Loss of Vision	No	Yes
Blurred Vision	No	Yes
Distorted Vision	No	Yes
Loss of Peripheral Vision	No	Yes
Double Vision	No	Yes
Dryness	No	Yes
Redness	No	Yes
Gritty or Foreign Body Sensation	No	Yes
Itching	No	Yes
Burning	No	Yes
Excess Tearing	No	Yes
Excessive Blinking	No	Yes
Lazy Eye/Crossed Eye	No	Yes
Flashing Lights	No	Yes
Floaters	No	Yes
Glare/Light Sensitivity	No	Yes
Pain or Soreness	No	Yes
Infection/Mucous Discharge	No	Yes
Tired Eyes	No	Yes
Drooping Eyelid	No	Yes
Other	No	Yes

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

Are you being treated for High Blood Pressure? Yes No **Diabetes?** Yes No

Previous eye injury or eye surgery _____

Have you ever had an injury to your head? _____ **A stroke?** _____

Medications: (Include Non-Prescription) _____

_____

Patient Social History:

Hobbies and Interests _____

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but not in the past _____ year(s) Current packs/day: _____

Do you have visual difficulty when driving? Yes No

Do you currently wear: Contact Lenses Glasses Over the counter Glasses Sunglasses None

Do you use a computer? Yes No If so, do you experience eye strain, headaches or fatigue during use? Yes No

Family Medical History:

	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

☐ **Ears/Nose/Mouth/Throat**

Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Hearing loss or injury	No	Yes
Sore throat or voice change	No	Yes

☐ **Neurological**

Numbness or tingling sensation	No	Yes
Paralysis	No	Yes
Headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Tremors	No	Yes
Head injury	No	Yes

☐ **Hematologic/Lymphatic**

Anemia	No	Yes
Bleeding or bruising tendency	No	Yes
Slow to heal after cut	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Respiratory**

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Asthma	No	Yes
Tuberculosis	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Frequent diarrhea	No	Yes
Nausea or vomiting	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Depression	No	Yes
Nervousness	No	Yes
Insomnia	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying down	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Musculoskeletal**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Muscle pain or cramps	No	Yes
Weakness pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Immunologic**

HIV Positive	No	Yes

☐ **Allergic Reactions to:**

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptics	No	Yes

☐ **Other drug/medication allergies:** _____

_____

_____

☐ **Known food allergies:** _____

_____

Medical Ins. Comp._____

PAYMENT POLICY: Payment is due at the time of service in order to keep your eyecare cost down. Any unpaid balances on materials must be paid before materials may be dispensed.

Method of Payment: Cash Check Visa / MC Medicare Vision Service Plan (VSP)

I understand that I am responsible for all charges regardless of my medical insurance coverage. I authorize the release of any medical information necessary to aid in the insurance claims or to aid in my care.

I have read and understand the above information and have answered the questions to the best of my knowledge.

Signature_____Date_____