

WELCOME TO (OR BACK TO) OUR OFFICE

02-09-07

To insure proper care, our doctors and many insurance companies, require a comprehensive medical health and visual history from all patients as part of their eye examination. Thank you for the privilege of allowing us to be of service to you and your family and thank you for your cooperation

Name: _____ Today's Date: _____
(Mr., Mrs., Ms., Dr., Master) First Middle Last (Preferred Name)

Street Address: _____ Phone: Home (_____) _____

City/ State/ Zip: _____ Cell # (_____) _____ Office (_____) _____

E-Mail Address: _____ If, with your permission, you desire to be contacted, by our office, through the internet.

Date of Birth: ____/____/____ Age: ____ Sex: M, F Marital Status: _____ Soc Sec #: _____

Employer/ Occupation: _____ School/grade or year:(if attending) _____

Spouse Name: _____ Spouses Occupation: _____ Office phone (_____) _____

Other family members living at home. Is your spouse a patient in our office? Yes No Spouses SS#/ Cell# _____/(_____) _____

Name: 1) _____ Age ____ Patient Here? Yes No 3) _____ Age ____ Yes No

2) _____ Age ____ Yes No 4) _____ Age ____ Yes No

For children, Mother's Name: _____ Father's Name: _____

Local person and phone number to notify in case of emergency: _____

Last EYE Exam: ____/____/____ Name & Location of your last eye doctor: _____

Last MEDICAL Exam: ____/____/____ Name and # of your doctor: _____ Is this your PCP? Yes No

Medical History: Do you take any medications? No yes If yes, please list all medicines including oral contraceptives, vitamins and OTC's. _____

Do you have any seasonal or medicine allergies? No Yes If yes, please explain _____

List all major injuries, surgeries or hospitalizations: _____

Women: Are you pregnant? Yes No If yes, what is your due date? _____ Are you nursing? Yes No

Personal and Family Eye History: Do you or does anyone in your immediate family have a history of the following?

	No	Self	Family	Describe briefly	No	Self	Family	Describe briefly
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed or lazy eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dry or scratchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Flashes or floaters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Redness or mucous	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you had any eye injuries or surgeries? No Yes. If yes, please explain _____

Personal / Family Health History and Review of Systems: Do you or does anyone in your immediate family have a history of the following?

(circle or underline specific issues)	No	Self	Family	No	Self	Family
Neurologic (headaches, migraines, seizures, MS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genito-urinary (kidney, bladder, prostate)	<input type="checkbox"/>	<input type="checkbox"/>
Blood, lymphatic (high cholesterol, anemia, hepatitis, bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine (diabetes, thyroid or other glands)	<input type="checkbox"/>	<input type="checkbox"/>
Ear, nose, throat (sinus, ear infections, dry mouth, chronic cough)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (asthma, emphysema, bronchitis)	<input type="checkbox"/>	<input type="checkbox"/>
Cardio-vascular (heart, high blood pressure, vascular disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric (anxiety, depression, insomnia)	<input type="checkbox"/>	<input type="checkbox"/>
Gastro-intestinal (stomach ulcers, diarrhea, constipation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (acne, warts, skin cancer, keloid formation)	<input type="checkbox"/>	<input type="checkbox"/>
Bones, joints, muscles (arthritis, osteoporosis, chronic fatigue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional (Fever, weight loss / gain)	<input type="checkbox"/>	<input type="checkbox"/>
Allergic or Immunologic (lupus, sarcoid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above please

explain: _____

==== Please turn form over and complete side 2====

