WELCOME TO FAMILY EYE CARE

Please take time to fill out this form. It will help us provide the best care for your vision and eye health. *Thank you for your cooperation.*

Mr.-Mrs.-Ms.-Dr. _____

Street _____

City _____ State_____ Zip _____

Home Phone _____

Cell Phone _____

E-Mail _____

Occupation or Grade of Patient _____

How did you hear about us? _____

What is the major reason for your exam today? _____

_____

Today's Date _____ Date of Last Exam _____

Date of Birth _____ Age ____ Full Time Student ◻ Yes ◻ No

Sex ◻ M ◻ F Social Security # _____

Spouse (or Parents' Names) _____

Spouse (or Parents' Names) Work Phone _____

Vision Insurance _____

Primary Medical Insurance _____

Secondary Medical Insurance _____

RACE: _____

ETHNICITY: ◻ Hispanic or Latino ◻ Not Hispanic or Latino

MEDICAL REVIEW OF SYSTEMS: *(Circle all that apply)*

Const. none / fatigue / developmental disorder
ENT none / sinus / dry mouth / hearing loss
Neuro none / migraine / stroke / CVA / epilepsy / MS / CP
Psych none / anxiety / bipolar / depression / ADD
Cardio none / high blood pressure / heart disease / stroke / vascular
Resp none / sleep apnea / asthma / bronchitis / emphysema
Gastro none / celiac / colitis / acid reflux / ulcer
Gen/Ur none / nursing / pregnant / prostate / kidney / herpes / chlamydia
Musc/Skel none / arthritis / osteoporosis / fibromyalgia / muscular dystrophy
Integ none / rosacea / eczema / psoriasis / shingles / acne
Endo none / thyroid / hormonal / diabetes Type I or Type II
Hem/Lymph none / anemia / large volume blood loss ! high cholesterol
Allergy / Imm none / enviro / food / drug / latex / sjogren's / lupus
OTHER: _____

PATIENT OCULAR REVIEW

◻ eye injury ◻ macular degeneration ◻ other
◻ eye surgery ◻ glaucoma _____
◻ laser vision correction ◻ retinal detachment
◻ cataract ◻ lazy eye
◻ cataract removal ◻ crossed eye

Do you or have you had any of these?

◻ night blindness ◻ spots/floaters ◻ styes
◻ light sensitivity ◻ light flashes ◻ itching
◻ double vision ◻ headaches ◻ burning
◻ eye strain ◻ nausea ◻ redness
◻ eye pain ◻ dizziness ◻ dryness
◻ blurry vision ◻ eye twitch ◻ tearing

CURRENT MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER) Name of Medication

Anti-depression ◻ No ◻ Yes _____
Allergy/Asthma ◻ No ◻ Yes _____
Diabetes ◻ No ◻ Yes _____
Diuretics Mater Pills") ◻ No ◻ Yes _____
High Blood Pressure ◻ No ◻ Yes _____
Heart Medication ◻ No ◻ Yes _____
Oral Contraceptives ◻ No ◻ Yes _____
Sleeping Tablets ◻ No ◻ Yes _____
Thyroid ◻ No ◻ Yes _____
Eye Medication ◻ No ◻ Yes _____
Cholesterol ◻ No ◻ Yes _____
OTHER: _____

FAMILY MEDICAL HISTORY

			Relationship
Glaucoma	◻ No	◻ Yes	_____
Macular Degeneration	◻ No	◻ Yes	_____
Cataracts	◻ No	◻ Yes	_____
Blindness	◻ No	◻ Yes	_____
Retinal Detachment	◻ No	◻ Yes	
Lazy Eye	◻ No	◻ Yes	
Crossed Eye	◻ No	◻ Yes	
Diabetes	◻ No	◻ Yes	
Heart Disease	◻ No	◻ Yes	
High Blood Pressure	◻ No	◻ Yes	
Arthritis	◻ No	◻ Yes	
OTHER	◻ No	◻ Yes	

ALLERGY TO MEDICATIONS

◻ Yes ◻ No _____

_____

_____

Where did you receive your last eye exam?

How long ago? _____

Any problems with your present contact lenses or glasses?

◻ Yes ◻ No Explain _____

What do you like about your present contact lenses or glasses?

_____

Have you ever worn, or are you currently wearing contact lenses?

◻ Yes ◻ No What kind? _____

Are you currently under a physician's care? ◻ No ◻ Yes

Physician's Name _____ City _____

SOCIAL HISTORY - Complete

Smoking status current / former / never

Drug use? Yes / No

Alcohol use? Yes / No How often?_____

Are you interested in purchasing glasses today? ◻ Yes ◻ No

Are you interested in Laser Vision Correction? ◻ Yes ◻ No

Are you interested in contact lenses? ◻ Yes ◻ No

Are you interested in sunglasses? ◻ Yes ◻ No

Signature _____