Keeping You in Sight

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Please Print

Name: ______________________

Street: ______________________

PO Box: ______________________

City: ____________ State _____ Zip ________
Give us your telephone numbers please:

Home # ____________Work # ____________
Cell # ____________

Employer (or School):______________________
Occupation (or Grade):______________________

Medical Insurance Co: ______________________

Policy #: ______________________

Vision Insurance: ______________________

Insured's Date of Birth: ______________________

Today's Date: ______________________

Date of Birth: ______________ Age: ________

Sex: M ☐ F ☐ Social Security #: ____________

Ethnic Origin: Asian Black Caucasian Hispanic
(Circle Choice)
Marital Status: Single Married Separated
Divorced Widowed
(Circle Choice)

Spouse or Parent Name: ______________________

Spouse or Parent Work Phone: ______________

Please give us your Medicare/Medicaid numbers:
Medicare #: ______________________

Medicaid #: ______________________

Your regular physician: ______________________

Nearest Relative Not Living With You: Relationship: Phone:

The following information is very important to your health. Please take the time to fully and accurately complete this form!

Eye History

Check this box if you have NO eye problems or symptoms: ☐ I have no eye problems

Do you have a history of eye problems other than glasses? ☐ Glaucoma ☐ Retinal Disease ☐ Cataract
☐ Other ______________________ ☐ Eye Surgery ______________________

Do you wear contact lenses? ☐Yes ☐No ***If yes, what type and power are your lenses?*** ______________

Do Your Eyes Experience Any of the Following?

☐ Burning	☐ Flashes of Light	☐ Strain/Headache
☐ Sensitivity to Light	☐ Floating Objects	☐ Gritty Feeling
☐ Excessive Tearing	☐ Blurry Distance Vision	☐ Itchiness
☐ Difficulty Seeing at Night	☐ Blurry Near Vision	☐ Soreness
☐ Uncomfortable Glasses	☐ Sudden Loss of Vision	☐ Redness
☐ Uncomfortable Contact Lenses	☐ Glare or Reflection	☐ Dryness
☐ Double Vision	☐ Other:______________________	

What is the MAIN purpose of this visit? What do you want to accomplish by seeing the doctor today?

PAYMENT IN FULL IS REQUIRED WHEN SERVICES ARE RENDERED IF THERE IS NO INSURANCE COVERAGE

You will be responsible for any portion of your bill which is not paid for by your insurance company.

How will you be paying for your visit? ☐ Check ☐ Cash ☐ Credit Card ☐ Insurance

(Please continue on back)

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Family Medical History — *Relationship*

Condition	Yes	No	Relationship
Blindness	☐ Yes	☐ No	________________
Cataracts	☐ Yes	☐ No	________________
Glaucoma	☐ Yes	☐ No	________________
Diabetes	☐ Yes	☐ No	________________
Hypertension	☐ Yes	☐ No	________________
Retinal Disease	☐ Yes	☐ No	________________
Stroke	☐ Yes	☐ No	________________
Heart Attack	☐ Yes	☐ No	________________

Social History

Do you smoke? ☐ Yes ☐ No
If yes, how much per day? ________________
Smoking Cessation Counseling Done: ☐ Yes

Drink alcohol? ☐ Yes ☐ No
Have you ever had a problem with drug abuse?
☐ Yes (see below) ☐ No
How much? ____________________________
If so, what drug? __________ When? _______

YOUR MEDICAL HISTORY

Medication Allergies: ____________________________
____

Major Surgeries: ________________________________
____

Review of Systems: If "YES" List Date of Problem

System	Yes	No	Date
Cardiovascular (Heart)	☐ Yes	☐ No	______________
Heart Attack?	☐ Yes	☐ No	______________
High Blood Pressure?	☐ Yes	☐ No	______________
Vascular Disease?	☐ Yes	☐ No	______________
Ear,Nose,Throat,Mouth	☐ Yes	☐ No	______________
Endocrine: **Diabetes**	☐ Yes	☐ No	______________
Insulin Use	☐ Yes	☐ No	______________
Thyroid	☐ Yes	☐ No	______________
Hormone	☐ Yes	☐ No	______________
Gastrointestinal	☐ Yes	☐ No	______________
Ulcer?	☐ Yes	☐ No	______________
Reflux?	☐ Yes	☐ No	______________
Bleeding?	☐ Yes	☐ No	______________
Genitourinary	☐ Yes	☐ No	______________
Kidney Stones?	☐ Yes	☐ No	______________
Bladder Infections?	☐ Yes	☐ No	______________
Immune System	☐ Yes	☐ No	______________
Problems with Your Immune System?	☐ Yes	☐ No	______________
Hematologic/Lymph	☐ Yes	☐ No	______________
Integumentary (Skin)	☐ Yes	☐ No	______________
Musculoskeletal	☐ Yes	☐ No	______________
Neurological	☐ Yes	☐ No	______________
Stroke?	☐ Yes	☐ No	______________
Psychiatric	☐ Yes	☐ No	______________
Reproductive	☐ Yes	☐ No	______________
Are You Pregnant?	☐ Yes	☐ No	______________
Are You Breast feeding?	☐ Yes	☐ No	______________
Menopause?	☐ Yes	☐ No	______________
Prostate Disease?	☐ Yes	☐ No	______________
Herpes?	☐ Yes	☐ No	______________
Other STD?	☐ Yes	☐ No	______________
Respiratory	☐ Yes	☐ No	______________
Asthma?	☐ Yes	☐ No	______________
COPD?	☐ Yes	☐ No	______________
Cancer History?	☐ Yes	☐ No	______________
Chemotherapy?	☐ Yes	☐ No	______________
Radiation?	☐ Yes	☐ No	______________

Type of Cancer? ________________________________

Medications (including Non-Prescription such as Aspirin, etc.)

Medicine	*Dosage*	*How Often?*

Eye Drops

____
____
____
____

Drug Store: ***Drug Store Phone:***
____

Other Important Health History Please Describe Here:

____
____
____
____
____

Patient Name:

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