PersonalEYES VISION CARE

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PATIENT INFORMATION

Last Name: _____

First Name: _____ Preferred Name:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different)_____

Cell Phone: _____ May we text you?: Y N

E-mail Address: _____ May we email you?: Y N

Referred by: _____Marital Status_____

Date of birth: ___/___/_____ Sex: M F Emergency Contact_____

Social Security Number: _ _ _ - _ _ - _ _ _ _ Primary Care Physician: _____

Employment Status: _____Full time_____Part time_____

Employer: _____ Occupation: _____

Insurance Information: Medical_____ Vision_____

Are you experiencing problems with your vision? Y N Preferred Pharmacy_____

Do you wear glasses? Y N

Do you wear contact lenses? Y N Do you want to wear contact lenses? Y N

If you wear contact lenses, how often do you replace them?—daily / wkly / 2 wks / 3 wks / monthly / as needed

Race:
- □ Native American Indian / Native Alaskan
- □ Asian
- □ Black / African American
- □ Hispanic
- □ Native Hawaiian / Other Pacific Island
- □ White

Ethnicity:
- □ Hispanic / Latino
- □ Native Hawaiian / Other Pacific Island
- □ Not Hispanic / Latino

Preferred Language, if other than English: _____

Communication Preferred: □ Email □ Text □ Home Telephone □ Cell Telephone □ Postal
(please check one or more)

Last Eye Exam: _____ Last Eye Doctor: _____

****** PLEASE COMPLETE THE HEALTH HISTORY ON THE BACK OF THIS SHEET ******

PATIENT HEALTH HISTORY

Medical / Family History

Please list all your current medications (include Rx prescriptions, over the counter, vitamins and herbal therapy)

_____

_____

_____

List all major surgeries (include eye surgeries) _____

_____

List any medications or eye drops that you are allergic to _____

_____

Please indicate if any of these conditions apply to you.

Disease / Condition	Yes	No
Cataract	□	□
Eye Turn	□	□
Glaucoma	□	□
Macular Degeneration	□	□
Retinal Detachment	□	□

	Yes	No
Women—Are you pregnant?	□	□
--Are you breast feeding?	□	□

Other eye problem _____

Please indicate if any of these conditions apply to a family member.

Disease / Condition	Yes	No	Relationship (Blood Relatives Only)
Cataract	□	□	_____
Eye Turn	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Retinal Detachment	□	□	_____

Review of Systems: Please indicate below if you now have, or if you have ever had problems with the following conditions:

Allergic / Immunologic
- □ None
- □ Lupus (SLE)
- □ Rheumatoid Arthritis
- □ Environmental Allergies
- □ Seasonal Allergies
- □ Other (i.e., Latex)

Ear, Nose and Throat
- □ None
- □ Sinusitis
- □ Upper Respiratory Tract Infections
- □ Other

Gastrointestinal
- □ None
- □ Crohn's Disease
- □ Colitis
- □ Acid Reflux / Ulcer
- □ Other

Skin/Integumentary
- □ None
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Acne
- □ Other

Psychiatric
- □ None
- □ Depression
- □ Bipolar
- □ Anxiety
- □ Schizophrenia
- □ Other (i.e., ADD)

Cardiovascular
- □ None
- □ High Blood Pressure
- □ Heart Disease
- □ High Blood Cholesterol
- □ Vascular Disease
- □ Stroke

Endocrine / Glands
- □ None
- □ Diabetes
- □ Hormone Dysfunction
- □ Thyroid Dysfunction
- □ Other

Respiratory
- □ None
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Sleep apnea
- □ Other

Muscle / Skeletal
- □ None
- □ Arthritis
- □ Fibromyalgia
- □ Ankylosing Spondylitis
- □ Other

Genital / Urinary
- □ None
- □ Urinary Tract Infections
- □ Genital Herpes
- □ Chlamydia
- □ HIV Positive
- □ Other

Hematologic / Lymphatic
- □ None
- □ Anemia
- □ Leukemia
- □ Bleeding Disorder
- □ Other

Neurological
- □ None
- □ Multiple Sclerosis
- □ Epilepsy
- □ Tremors
- □ Other

General Health
- □ None
- □ Recent:
  - □ Fever
  - □ Fatigue
  - □ Trauma
  - □ Weight loss/gain

Social
- Alcohol consumption_Y_N_____
- Illegal drug use_Y_N_____
- Tobacco Use:
  - □ Current Smoker
  - □ Former Smoker
  - □ Non-smoker

Please sign below to acknowledge that this form is correct:

Signature: _____Date:_____Reviewed by Doctor's initials:_____