Family Eye Care Center

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Name:_____ Date:_____/_____/_____

Preferred Name:_____ Birth Date:_____/_____/_____ Gender: ☐ Male ☐ Female

Address:_____ City:_____

State:_____ Zip:_____ E-mail Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Occupation:_____ Employer:_____

Spouse:_____ Spouse's work phone:_____

Person responsible for account:_____

Billing address (if different from above):_____

_____

How were you referred? ☐ Other Patient who?_____ ☐ Phone Book ☐ Location

☐ Physician who?_____ ☐ Other _____

Medical History

Name of Medical Doctor:_____ Last Medical Exam:_____/_____/_____

Do you have any allergies to any medications? ☐ no ☐ yes If yes, please explain: _____

_____

_____

List any medications you use (including contraceptives, aspirin, over the counter medications and home remedies):_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had:_____

_____

Are you pregnant and/or nursing? ☐ no ☐ yes

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Family History

Please note any family history (parents, grandparents, siblings, children) for the following conditions: (list relationship in blank)

Blindness ☐ no ☐ yes_____ Macular Degeneration ☐ no ☐ yes _____

Glaucoma ☐ no ☐ yes_____ Retinal Detachment/Disease ☐ no ☐ yes_____

Cataract ☐ no ☐ yes_____ Crossed Eyes ☐ no ☐ yes_____

Arthritis ☐ no ☐ yes_____ Heart Disease ☐ no ☐ yes_____

Cancer ☐ no ☐ yes_____ High Blood Pressure ☐ no ☐ yes_____

Diabetes ☐ no ☐ yes_____ Kidney Disease ☐ no ☐ yes _____

Lupus ☐ no ☐ yes_____ Thyroid Disease ☐ no ☐ yes_____

Other Condition(s) Not Listed _____

Name:_____ Date:_____/_____/_____

Social History

Hobbies _____

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long:_____

Do you drink alcohol? ☐ no ☐ yes If yes, type/amount/how long:_____

Do you use any other recreational or illegal drugs? ☐ no ☐ yes If yes, type/amount/how long:_____

Review of Systems – Are you currently having problems with, been diagnosed with, or currently being treated for …..

Eyes	**No**	**Yes**
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Infection of Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes/Floater in Vision	☐	☐
Tired Eyes	☐	☐
Crossed Eyes	☐	☐
Eye Injury	☐	☐

Constitutional	**No**	**Yes**
Fever, Weight Loss/Gain	☐	☐
Integumentary		
Dry Skin	☐	☐
Breast Cancer	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐
Ear, Nose, Mouth, Throat		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose/Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Lung Cancer	☐	☐
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐

Vascular/Cardiovascular	**No**	**Yes**
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Ulcers	☐	☐
Genitourinary		
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric		
Depression	☐	☐
Nervous Disorder	☐	☐

Other Condition(s) Not Listed _____

Vision Insurance Provider:_____

Primary Medical Insurance Provider: _____

Secondary Medical Insurance Provider(s):_____

When was your last eye examination? _____/_____/_____

Signature: _____ Date:_____/_____/_____

Payment is expected at time of service, unless prior arrangements have been made

We will need a copy of your insurance card(s) if applicable. Thank You!