FAMILY EYE CARE CENTER

PATIENT INFORMATION

Name – Last_____ Middle Initial_____ First_____ Nickname_____

Date of birth_____/_____/_____ If a Minor, Parent/Guardian Name(s)_____

Sex (circle one): Male or Female Social Security Number_____ – _____ – _____

Address – Street_____ City_____ State_____ Zip Code_____

Phone – Home: (_____)_____ Cell (_____)_____

Email_____ Communication Preference: Email, Postal, Telephone (circle one)

Married, Single, Divorced, Separated, Widowed, Minor (circle one)

Employer/Occupation_____

Medical Doctor/Clinic_____ Which pharmacy do you prefer?_____

Per Federal Regulations, please circle the appropriate option for the following:

PREFERRED LANGUAGE
English
Spanish
French
Japanese
Other

ETHNICITY
Hispanic or Latino
Native Hawaiian/Other Pacific Islander
Not Hispanic or Latino

RACE
American Indian or Alaska Native
Asian
Black or African American
Hispanic
Korean
Native Hawaiian/Other Pacific Islander
White

INSURANCE

Who is responsible for this account?_____ Relationship to patient_____

Vision Insurance _____ Subscriber's Name_____

Date of birth_____/_____/_____ Social Security Number_____ – _____ – _____

Employer_____

Medical Insurance _____ Subscriber's Name_____

Date of birth_____/_____/_____ Social Security Number_____ – _____ – _____

Employer_____

Relationship to patient_____

PATIENT EYE HEALTH HISTORY

Do you wear glasses?	Yes	No
Do you wear contact lenses?	Yes	No

If yes: Brand_____ Replacement schedule_____

Are you experiencing any of the following EYE symptoms?

Blurred vision (near)	Yes	No
Blurred vision (distance)	Yes	No
Loss of vision	Yes	No
Double vision	Yes	No
Distorted vision	Yes	No
Haloes	Yes	No
Dryness	Yes	No
Mucous discharge	Yes	No
Redness	Yes	No
Sandy/gritty feeling	Yes	No
Itching/burning	Yes	No
Foreign body sensation	Yes	No
Excess tearing/watering	Yes	No
Excessive light sensitivity	Yes	No
Flashes/floaters	Yes	No
Eye fatigue	Yes	No
Twitching eyelid(s)	Yes	No

PATIENT OCULAR HISTORY

Have you ever been diagnosed with any of the following? If yes, please indicate which eye(s).

Blindness	Yes	No	Left / Right
Cataract	Yes	No	Left / Right
Glaucoma	Yes	No	Left / Right
Injury/trauma	Yes	No	Left / Right
Lazy eye	Yes	No	Left / Right
Macular Degeneration	Yes	No	Left / Right
Retinal Disease	Yes	No	Left / Right
Retinal hole/detachment	Yes	No	Left / Right

Have you had any of the following eye surgeries?

Cataract surgery	Yes	No	Left / Right
Lid surgery	Yes	No	Left / Right
Punctal Plugs	Yes	No	Left / Right
Refractive surgery (LASIK)	Yes	No	Left / Right
Retinal Hole/detachment	Yes	No	Left / Right
Strabismus (eye muscle)	Yes	No	Left / Right

SOCIAL HISTORY

Smoker (circle one): Never Former Current

Current smokeless tobacco user: Yes No

Alcohol Use : None Socially Above average use Alcohol dependency

PATIENT HEALTH HISTORY (Review of Systems)

Height_____ft _____in Weight _____lbs

Are you currently pregnant or nursing? Yes No

Do you CURRENTLY or have you EVER had any problems in the following areas?

ALLERGY

Environmental (please list) _____

Medications (please list) _____

CARDIOVASCULAR		
Elevated Cholesterol	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
CONSTITUTIONAL		
Appetite excess/loss	Yes	No
ENDOCRINE		
Diabetes	Yes	No
Thyroid Disorder	Yes	No
GASTROINTESTINAL		
Nausea	Yes	No
GENITOURINARY		
Bladder Disease	Yes	No
Kidney Disease	Yes	No
Sexually Transmitted Disease	Yes	No
HEAD (Ear, Nose, Mouth, Throat)		
Headache	Yes	No
Migraine	Yes	No
Sinusitis	Yes	No
HEMATOLOGIC/LYMPHATIC		
Sickle Cell Disease	Yes	No
Temporal Arteritis	Yes	No

IMMUNOLOGIC		
HIV Positive	Yes	No
Herpes Simplex	Yes	No
Herpes Zoster (Shingles)	Yes	No
Sjogren's Disease	Yes	No
INTEGUMENTARY		
Acne	Yes	No
Acne Rosacea	Yes	No
Lupus	Yes	No
MUSCULOSKELETAL		
Arthritis	Yes	No
Myasthenia Gravas	Yes	No
NEUROLOGICAL		
Bell's Palsy	Yes	No
Muscular Sclerosis	Yes	No
PSYCHIATRIC		
Attention Deficit Disorder	Yes	No
Autism	Yes	No
Depression	Yes	No
RESPIRATORY		
Asthma	Yes	No
COPD	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No

If you answered YES to any of the above, or have had conditions/surgeries not listed, please explain:

_____

_____

Are you currently taking any systemic medications?

_____

_____

Are you currently taking any eye medications?

_____

_____

FAMILY HISTORY

Has anyone in your FAMILY (parents, grandparents, children) been diagnosed with any of the following?

Lazy Eye	Yes	No	Blindness	Yes	No
Glaucoma	Yes	No	Diabetes	Yes	No
Macular degeneration	Yes	No	High blood pressure	Yes	No
Retinal disease	Yes	No			

I authorize Family Eye Care Center to release to my insurer(s) and their agents any information needed to determine eye care benefits or benefits for related services. I also accept responsibility for and agree to pay in full any fees for services/goods that are not paid by my insurer(s).

_____ _____/_____/_____

Signature of Beneficiary, Guardian, or Personal Representative Date