FAMILY EYE CARE CENTER

PATIENT INFORMATION

Name: Last_____ M.I. _____ First_____

Preferred Name _____ Date of birth _____ /_____ / _____

Married, Single, Divorced, Separated, Widowed, Minor (circle one) If a Minor, Parent/Guardian Name(s)_____

Sex (circle one): Male or Female Patient's Social Security Number _____ - _____ - _____

Address: Street_____ City_____ State_____ Zip Code _____

Cell Phone (_____) _____ Alternate Phone (_____) _____

Email _____

Employer/Occupation_____

Medical Doctor/Clinic_____ Pharmacy (and location) _____

INSURANCE

Who is responsible for this account?_____Relationship to patient _____

Vision Insurance _____ Subscriber's Name _____

Date of birth _____ /_____ /_____ Subscriber's Social Security Number _____ - _____ - _____

Employer_____

Medical Insurance _____ Subscriber's Name_____

Date of birth _____ /_____ /_____ Subscriber's Social Security Number _____ - _____ - _____

Employer _____

Relationship to patient _____

PATIENT OCULAR HISTORY

Do you wear glasses? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

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

Blindness	Right / Left	Retinal disease	Right / Left
Cataract	Right / Left	Retinal hole/detachment	Right / Left
Glaucoma	Right / Left	Other eye disease (please explain)	Right / Left
Injury/trauma	Right / Left	_____	
Lazy eye (strabismus)	Right / Left	_____	
Macular degeneration	Right / Left	_____	

If you have had any of the following eye surgeries, please circle the corresponding eye(s) and provide the date of the procedure.

Cataract surgery	Right	Date____/____/____	Refractive surgery (LASIK)	Right / Left Date____/____/____
	Left	Date____/____/____	Retinal hole/detachment	Right / Left Date____/____/____
Lid surgery	Right / Left	Date____/____/____	Strabismus (eye muscle)	Right / Left Date____/____/____
Punctal plugs	Right / Left	Date____/____/____		

Please complete the reverse side of the form.

PATIENT HEALTH HISTORY

ALLERGY

Allergies to medications _____

Environmental allergies _____

CARDIOVASCULAR

Elevated Cholesterol	Yes	No
High Blood Pressure	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No

ENDOCRINE

Diabetes Type I	Yes	No
Diabetes Type II	Yes	No
Thyroid Disorder	Yes	No
PCOS	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 Gravis	Yes	No

NEUROLOGICAL

Bell's Palsy	Yes	No
Multiple Sclerosis	Yes	No
Epilepsy/Seizures	Yes	No

PSYCHIATRIC

Attention Deficit Disorder	Yes	No
Autism	Yes	No
Depression	Yes	No
Anxiety	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 pregnant or nursing? Yes No

Tobacco use? Yes No Former

Are you currently taking any eye medications? Please list.

_____

_____

Are you currently taking any other medications? Please list.

_____

_____

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