



WELCOME TO OUR PRACTICE

(Dr./Mr./ Mrs./ Ms./ Miss) DATE:

Name Date of Birth Age SSN

Address Occupation Employer

City/State/Zip Spouse

Phone (H) Cell Work

Name of Parent or Guardian Email address

Referred by: Phone book Radio Newspaper Person(s)

Insurance Other

INSURANCE INFORMATION

Many health issues related to the eyes are covered by insurance. Please indicate your health and vision insurance. If you have an eye health condition your health insurance may be billed.

Medicare Blue Cross/Blue Shield United Health Care Aetna

Other

Vision Service Plan Vision Care Eyemed Other

Personal Eye History:

Last eye examination Where? Dr.'s Name

Have you ever had any eye operations? Y/N

Type Date

Have you ever had any eye injuries? Y/N

Describe Date

Have you been diagnosed with Glaucoma Y/N Cataracts Y/N Macular degeneration Y/N

Diabetic retinopathy Y/N Other

Do you wear glasses? Y/N Contacts Y/N Soft / Hard Brand Powers

Are your glasses and / or contacts comfortable? Y/N if not describe discomfort

Is your vision clear with the glasses? Y/N contacts Y/N

How long have you worn glasses and/or contacts?

Family Eye History:

Family history of Glaucoma Y/N Who? Cataracts Y/N Who?

Macular degeneration Y/N Who? Retinal detachments Y/N Who?

Diabetes Y/N Who? Other

REVIEW OF SYSTEMS

Eyes:

Loss of vision Y/N

Distorted vision Y/N

Double vision Y/N

Redness Y/N

Itching Y/N

Watering/Tearing Y/N

Eye pain Y/N

Blurred vision Y/N

Loss of side vision Y/N

Mucous discharge Y/N

Sandy or Gritty feeling Y/N

Burning Y/N

Bothered by Glare Y/N

Floaters Y/N



Yes No

**Ears, Nose, Mouth, Throat**

- Sinus congestion \_\_\_\_\_
- Dry mouth/throat \_\_\_\_\_
- Cold sores \_\_\_\_\_

**Cardiovascular**

- High Blood Pressure \_\_\_\_\_
- Chest pain \_\_\_\_\_
- Angina \_\_\_\_\_
- Heart attack \_\_\_\_\_

**Respiratory**

- Shortness of breath \_\_\_\_\_
- Asthma / Emphysema \_\_\_\_\_
- Cough \_\_\_\_\_

**Gastrointestinal**

- Ulcers \_\_\_\_\_
- Colitis \_\_\_\_\_
- Hepatitis \_\_\_\_\_

**Genitourinary**

- Kidney disease \_\_\_\_\_
- Bladder infections \_\_\_\_\_

**Musculoskeletal**

- Arthritis \_\_\_\_\_
- Joint pain \_\_\_\_\_

**Neurological**

- Migraine \_\_\_\_\_
- Headaches \_\_\_\_\_
- Stroke \_\_\_\_\_
- Nervous disorders \_\_\_\_\_
- Seizures \_\_\_\_\_

**Endocrine**

- \*\*Diabetes Type \_\_\_\_\_  
Date of diagnosis \_\_\_\_\_  
Last Blood Sugar Reading \_\_\_\_\_
- Thyroid disease \_\_\_\_\_

**Hematological**

- Anemia \_\_\_\_\_
- Blood transfusions \_\_\_\_\_
- Sickle Cell \_\_\_\_\_
- Leukemia \_\_\_\_\_
- Significant loss of blood \_\_\_\_\_

Yes No

**Allergies and Immunologic**

- Medication Allergies \_\_\_\_\_
- Seasonal Allergies \_\_\_\_\_
- HIV \_\_\_\_\_

**Social History**

- Do you smoke? Packs per day \_\_\_\_\_
- Do you drink alcohol? How much \_\_\_\_\_

**Primary Care Doctor**

Name \_\_\_\_\_  
 Location \_\_\_\_\_  
 Last visit \_\_\_\_\_

**List of Current Medications**

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**Eye Medications:**

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**Additional Information (please list any health issues not addressed in this questionnaire)**

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Doctors signature \_\_\_\_\_

Date reviewed \_\_\_\_\_

Updated \_\_\_\_\_  
 Updated \_\_\_\_\_  
 Updated \_\_\_\_\_  
 Updated \_\_\_\_\_