eyecarecenter

PATIENT HISTORY

Today's Date_______________

Last Name_______________________ Suffix_____ First Name_____________________ Middle Initial _____

Address_____________________________________ Marital Status (circle one) Sgl M D W Separated

City__________________ State_____ ZIP_______ Race__________ Preferred Language __________Ethnicity __________

Home Phone ________________ Work Phone __________________ Cell Phone ____________________

Date of Birth ___________ Age ____ Sex: M F Social Security #______________ Email____________________

Employer _________________ Occupation _____________ Preferred Communication (circle): Phone Postal Email

Guarantor/Emergency Contact ____ Phone ( ) __________________

Insurance Company __________________________ Primary Policy Holder ______________________________
Patient's Relationship to Policy Holder (circle one) Self Spouse Child

Any telephone/cellular numbers provided by you may be subject to receiving calls from an automated dialer using a pre-recorded or live operator call. You give your prior consent to receive such phone/cellular calls. (Initial) _________

MEDICAL INFORMATION

DO YOU HAVE ANY PROBLEMS WITH ANY OF THESE SYSTEMS (PLEASE CHECK)

- ❑ **NONE**
- ❑ Respiratory
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Thyroid
- ❑ Headaches
- ❑ Gastrointestinal/Urinary
- ❑ Neurological
- ❑ Blood/Lymph
- ❑ Muscle/Joint
- ❑ Mental
- ❑ Cancer
- ❑ Seasonal Allergies

Other Please explain____

Primary Care Doctor ______________________________Do you smoke? Yes / No Amt per day____________

Use Alcohol? Yes No Freq_______ Use illegal drugs? Yes No Have you been exposed to or infected with: ____HIV ____Hepatitis

Past Surgery & Year____

Current Medication(s) ____

Allergies to Med(s) ___________________________ Female Patients: Are you pregnant? Yes No Nursing? Yes No

OCULAR HISTORY

Date of last exam______________________

- ❑ **NONE**
- ❑ Blurry Vision
- ❑ Eye Surgery
- ❑ Loss of Vision
- ❑ Eye Injury
- ❑ Glaucoma
- ❑ Dry Eyes
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Cataracts
- ❑ Flashes/Floaters
- ❑ Eye Allergies
- ❑ Glare/Light Sensitivity

FAMILY HISTORY

	RELATION		RELATION
❑ **NONE**			
❑ High Blood Pressure	________	❑ Glaucoma	________
❑ Diabetes	________	❑ Blindness	________
❑ Stroke	________	❑ Macular Degeneration	________
❑ Cataract	________	❑ Retinal Detachment	________

Do you have more than one pair of current RX glasses?	YES	NO	Do you wear sunglasses outside?	YES	NO
Do you work on the computer for long periods?	YES	NO	Do you spend a lot of time outdoors?	YES	NO
Are you satisfied with your current contact lenses?	YES	NO	Are there times you'd rather not wear glasses?	YES	NO
Interested in learning about laser vision correction?	YES	NO			

I have read and understand the HIPAA Notice of Privacy Practices ______________________________

****** (Signature) *****

DOCTOR'S USE ONLY: REVIEWED BY _______________ **DATE**__________