WELCOME TO OUR OFFICE

In order for us to get to know you better, we would appreciate if you took a few moments to answer the following questions.

Full Legal Name_____ Today's Date ____/____/_____
Mailing Address_____ Birth Date ____/____/_____
City _____ State _____ Zip _____ Social Security # _____
Home Phone _____ Work Phone _____ Gender: __ Male __ Female
Cell Phone _____ Occupation _____
Marital Status:__ Single __ Married email_____
Medical Doctor _____ Insurance Plan _____
Person Insured _____ Relationship _____ Insured Birth Date ____/____/_____
Insured Social Security/ID # _____ Insured Employer _____

Medical History

Please circle if you have or have ever had any problems in the following areas:

Eyes

- Cataracts
- Glaucoma
- Macular Degeneration
- Retinal Detachment
- Lazy Eye
- Eye Surgery
- Loss of Vision
- Double Vision
- Floaters or Light Flashes
- Eye Pain
- Burning, Tearing, Itching
- Redness or Discharge
- Dryness or Scratching
- Eye Infections
- Blindness
- Eye Discharge
- Eye Injury
- Itchy Eyes
- Light Sensitivity
- Poor Color Vision

Cardiovascular

- High Blood Pressure
- Heart Disease
- Elevated Cholesterol
- Irregular Heart Beat

Neurological

- Migraines
- Other headaches
- Seizures
- Stroke

Endocrine

- Thyroid (Hyper, Hypo)
- Diabetes ____ # of years

Ears, Nose, Mouth, Throat

- Allergies
- Sinus Congestion
- Dry Mouth/Throat

Respiratory

- Asthma
- Chronic Bronchitis
- Emphysema

Integumentary

- Skin Disease/Rash
- Eczema
- Rosacea
- Shingles

Gastrointestinal

- Crohn's Disease
- Irritable Bowel

Bones, Joints, Muscles

- Gout
- Osteoarthritis
- Osteoporosis

Lymphatic/Hematologic

- Anemia
- Bleeding Disorder

Autoimmune

- Multiple Sclerosis
- Lupus
- Rheumatoid Arthritis
- Sjorgren's Syndrome

Infectious Disease

- AIDS/HIV
- Hepatitis (Type ___)

Psychiatric

- Dementia
- Depression
- Anxiety
- Bi-polar

Other

- Cancer (Type _____)
- Lyme Disease
- Epilepsy
- PCOS

Other Conditions _____

_____
_____
_____

List all medications you are taking including eye drops, vitamins or over-the-counter medication:

_____

_____

_____

_____

List all allergies to medications and the type of reaction you had:

_____

_____

List any surgeries you have had:_____

_____

Do you presently wear: ___ glasses ___ contact lenses Are you interested in contacts Y N

Family History

Please circle if any family members have or had the following conditions:

Glaucoma	Diabetes
Cataracts	High Blood Pressure
Macular Degeneration	Heart Disease
Retinal Degeneration	Thyroid Disease
Blindness	Other _____

Social History

Tobacco Use: __ Never smoked __ Occasional Use __ Smokeless Tobacco
__ Former Smoker __ Daily Use

Do you drink? __Never __Social __1-2 Drinks Daily __More

Recreational Drug Use? Y N If yes, how often? _____

Other information you would like the doctor to know about yourself:

_____

_____

I, the undersigned, have insurance as noted on this form and assign directly to Eyecare of the Valley all medical benefits, if any otherwise payable to me for services rendered. I hereby authorize the release of all information necessary to secure the payment of benefits. In addition, I authorize the use of this signature for insurance submissions, and for billing purposes, if necessary, as well as verification of current medications listed.

I UNDERSTAND THAT I AM FINANCIALLY RESPOSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSURANCE.

Signed: _____ Date: _____

☐ Check if signed by parent or guardian, Name of guardian _____

Signed: _____ Date: _____

☐ Check if signed by parent or guardian, Name of guardian _____

Signed: _____ Date: _____

☐ Check if signed by parent or guardian, Name of guardian _____

Signed: _____ Date: _____

☐ Check if signed by parent or guardian, Name of guardian _____