PRECISION EYE CARE

Patient Information

Today's Date:_____

First_____MI_____

Last_____Nickname_____

Street_____

City_____State_____Zip_____

Date of Birth_____ Age_____

Sex: ☐ Male ☐ Female

Check Appropriate Box:

☐ Minor ☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

Home Phone_____

Work Phone_____

Cell Phone_____

Patient's SSN_____

Employer (or School)_____

Occupation (or Grade)_____

Spouse (or Parent)_____

Email Address_____

Communication Preference:

☐ Email ☐ Cell ☐ Mail ☐ Home Phone

Language Preference: ☐ English ☐ Other_____

Race:

☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hispanic/Latino

☐ Native Hawaiian/Pacific Islander ☐ White

Whom may we thank for referring you to our office?

Name_____

If not referred, how did you choose our office?

☐ Another Doctor_____
☐ Insurance list
☐ Saw sign/building
☐ Flyer/Magazine_____
☐ Web Page: which web site?_____
☐ Other_____

Insurance Information

Vision Insurance_____

ID Number (if any)_____

Subscriber Name_____

Subscriber SSN_____

Subscriber Birth Date_____

Primary Medical Insurance_____

Subscriber Name_____

Subscriber ID Number_____

Subscriber Birth Date_____

Secondary Medical Insurance_____

Subscriber Name_____

Subscriber ID Number_____

Subscriber Birth Date_____

Do you have a flex spending account? ☐ Yes ☐ No

Pharmacy Name_____

Pharmacy location_____

Eye Conditions

Have you experienced, been diagnosed or treated for any of the following?

☐ Blurry vision
☐ Burning
☐ Crossed eye/lazy eye
☐ Discharge
☐ Double vision
☐ Dryness
☐ Eye pain
☐ Flashes of light
☐ Floaters/spots
☐ Grittiness
☐ Headaches
☐ Itchiness
☐ Light sensitivity
☐ Redness
☐ Tearing
☐ Tired eyes
☐ Trouble seeing at night
☐ Cataracts
☐ Corneal abrasions
☐ Diabetic retinopathy
☐ Eye infections
☐ Eye injury
☐ Glaucoma
☐ Iritis/uveitis
☐ Macular degeneration
☐ Retinal detachment
☐ Other eye conditions

_____

☐ Problems with your current contact lenses or glasses

_____

☐ Are you interested in trying contact lenses?
☐ Are you interested in LASIK eye surgery?

Patient Medical History

Medical doctor_____

Office Phone Number_____

Date of last check-up_____

Do you currently have any of the following?

Allergies to medications?

☐ No ☐ Yes, which?_____

Cardiovascular/vascular problems (e.g., high blood pressure, heart disease, high cholesterol)?

☐ No ☐ Yes, explain_____

Chronic fever/unexpected weight loss or gain/fatigue?

☐ No ☐ Yes, explain_____

Endocrine problems (e.g. diabetes, thyroid disease)?

☐ No ☐ Yes, explain_____

Gastrointestinal problems (e.g., Crohn's disease, IBS, diarrhea, constipation, vomiting)?

☐ No ☐ Yes, explain_____

Genitourinary problems (e.g., STDs, kidney, bladder)?

☐ No ☐ Yes, explain_____

Ear/Nose/Throat problems (e.g., hearing loss, sinus problems, allergies, sore throat, dry mouth, cough?)

☐ No ☐ Yes, explain_____

Blood/Lymph problems (e.g., anemia, bleeding problems, swollen glands)?

☐ No ☐ Yes, explain_____

Immune problems (e.g., autoimmune diseases or infections)?

☐ No ☐ Yes, explain_____

Skin problems (e.g., skin conditions or growths)?

☐ No ☐ Yes, explain_____

Musculoskeletal problems (e.g., muscle aches, joint pain, arthritis)?

☐ No ☐ Yes, explain_____

Neurological problems (e.g., migraines, weakness, headaches, blackouts, seizures)?

☐ No ☐ Yes,explain _____

Psychiatric problems (e.g., depression, anxiety)?

☐ No ☐ Yes, explain_____

Respiratory problems (e.g., shortness of breath, wheezing, coughing, asthma)?

☐ No ☐ Yes, explain_____

Other Conditions_____

_____

_____

Current medications (Rx, vitamins, over the counter)

_____

_____

_____

_____

_____

_____

Do you currently use tobacco products?

☐ No ☐ Yes, if yes please specify below

Packs per day_____ Number of years_____

Have you ever used tobacco products? ☐ No ☐ Yes

Do you drink alcohol?

☐ No ☐ Yes (how much/often?)_____

Do you use illegal drugs?

☐ No ☐ Yes (how much/often?)_____

Are you ☐ Pregnant? ☐ Nursing?

Patient Eye History

Date of Last Eye Exam _____

By whom?_____

Do you use eye drops or medications?

☐ No ☐ Yes (explain)_____

Have you ever had any eye surgeries?

☐ No ☐ Yes (explain)_____

How old are your present glasses?_____

Have you ever tried contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What brand?_____

Prescription:

Right: power_____ base curve (bc) _____

Left: power_____ base curve (bc) _____

Solutions used_____

Is there a family medical history of any of the following:

(Please specify which family member **AND** whether on Mother's or Father's side)

Blindness ☐_____

Cataracts ☐_____

Corneal problems ☐_____

Diabetes ☐_____

Glaucoma ☐_____

Heart disease ☐_____

Hypertension ☐_____

Lazy eye ☐_____

Macular degeneration ☐_____

Retinal problems ☐_____