HEALTHY EYES
FAMILY VISION CARE

Date:_____

Patient Name: (*Last*)_____(*First*)_____(MI)_____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (*Cell*)_____(*Home*)_____(*Work*)_____

Email: _____

** DO YOU ACCEPT TEXT MESSAGES?* ☐ Yes ☐ No

Birthdate: _____ Age: _____ Gender: ☐ M ☐ F

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Other

Employer: _____Occupation _____

Race: (choose all that apply) ☐ White or Caucasian ☐ American Indian or Alaskan Native

☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

How did you hear about us? ☐ Driving By ☐ Doctor Referred ☐ Family / Friend

☐ Facebook/Website ☐ Screening or Event ☐ Newspaper ☐ Insurance

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Emergency Contact: _____Relation: _____Phone:_____

Parent (if patient under age of 18): _____Phone:_____

Family Physician/Pediatrician: _____Phone:_____

Pharmacy: _____Phone:_____

Insurance:

Medical Insurance: _____ Vision Insurance: _____

Policy Holder: _____ Date of Birth:_____ Last 4 of SSN:_____

Family Health History: (*Check if known in blood relatives*)

☐ High blood pressure

☐ Diabetes

☐ Cancer: Type _____

☐ Other _____

☐ Glaucoma: _____

☐ Cataract: _____

☐ Lazy Eye: _____

☐ Macular Degeneration: _____

Personal Ocular History:

☐ Glaucoma ☐ Lazy Eye **Last eye exam**: _____

☐ Cataract ☐ Macular Degeneration Currently wear glasses? ☐ YES ☐ NO

☐ LASIK ☐ Retinal Detachment Currently wear contact lenses? ☐ YES ☐ NO

If so, *Type/Powers:* _____

We would like to know more about your daily visual demands:

Sports/Hobbies: _____

Reading: Hours per Day _____ Computer Use: Hours per Day _____

Do you ever experience any of the following? (*Please check all that apply*)

☐ Dryness ☐ Watering ☐ Blurred Vision ☐ Floaters

☐ Burning ☐ Itching ☐ Flashes of Light ☐ Eye Pain

Personal Health History: (*Check if you have had any of the following*) ☐ Other/not listed below: _____

Constitutional	**ENT**	**Neurological**	**Psychiatric**	**Cardiovascular**
☐ Development Disability	☐ Hearing Loss	☐ Multiple Sclerosis	☐ Depression	☐ High Blood Pressure
☐ Cancer	☐ Ear ache/Tinnitus	☐ Epilepsy	☐ Attention Deficit	☐ Stroke
☐ Fatigue Syndrome	☐ Dry Mouth	☐ Cerebral Palsy	☐ Anxiety	☐ Heart Disease
☐ Trauma	☐ Sinusitis	☐ Migraine	☐ Bipolar	☐ Congestive Heart Failure

Respiratory	**Gastrointestinal**	**Genitourinary**	**Musculoskeletal**	**Integumentary**
☐ Asthma	☐ Crohn's	☐ Kidney Disease	☐ Osteoarthritis	☐ Eczema
☐ Bronchitis	☐ Colitis	☐ Kidney Stones	☐ Fibromyalgia	☐ Rosacea
☐ Emphysema	☐ Ulcers/Acid Reflux	☐ Enlarged Prostate	☐ Muscular Dystrophy	☐ Psoriasis
☐ Sleep Apnea	☐ Celiac Disease	☐ STD	☐ Ankylosing Spondylitis	☐ Cold Sores/Shingles

Endocrine	**Hematologic**	**Immunologic**
☐ Diabetes: (circle one) Type 1 - Type 2	☐ Anemia	☐ Rheumatoid Arthritis
(circle one) Diet Only - Medication - Insulin	☐ Sickle Cell	☐ Lupus
☐ Thyroid Disorder	☐ Leukemia	☐ Sjogren's
☐ Hormone Dysfunction	☐ High Cholesterol	☐ HIV/AIDS

Allergies: ☐ None Drug _____ Environmental _____

Are you currently ***pregnant*** or ***nursing***? (circle if Yes)

Current Medications, Reason: (*Including Over-the-Counter*) ☐ None

_____

_____

_____

Date of last examination with your Primary Care Physician: _____ Height: _____ft _____in Weight: _____lbs

Operations, Dates: _____

Smoking Status: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker: Packs per day _____

Alcohol Intake: ☐ None ☐ Socially ☐ Daily: Drinks per day _____