PATIENT INFORMATION

FAMILY EYE CARE

Name _____ Date_____

Age_____ Date of Birth_____ M F Who referred you to our office? _____

Employer or Current Grade in School_____ Email Address _____

Primary Care Physician's Name _____ Office _____

Copy of Current Medications: (We can copy your list) _____

Medical Allergies: _____

Over the Counter Medications: _____

YES	NO		
____	____	Do you enjoy reading?	How long can you read comfortably? _____
____	____	After reading or doing other close work do you look up and notice that objects are momentarily blurred?	
____	____	Do your eyes itch, burn, water, pull, ache, or feel dry?	
____	____	Do you ever experience double vision?	
____	____	Do you see halos around lights, floaters, or apparent flashes of light?	
		If so, which? _____	Have they changed recently? _____
____	____	Have you ever had any operations or injuries to your eyes?	
		If so, please list and date. _____	
____	____	Does using a computer cause eyestrain? _____	
____	____	How much time do you use hand-held electronic media? (iPad, Text) _____	
____	____	What are your pastimes? _____	
____	____	Are you involved in any hazardous occupations, pastimes, or sports?	
		If so, which ones? _____	
____	____	Is driving stressful to you?	
____	____	Is there any history in your blood relatives of any eye problems including Glaucoma, detached retina, or	
____	____	Macular Degeneration? If so, which relatives have which conditions? _____	
____	____	Have you had any recent gain or loss of weight?	
____	____	Do you get adequate rest?	
Cardiovascular	____	____	Do you have high blood pressure?
	____	____	Do you have a history of heart problems or stroke?
Neurological	____	____	Do you have a history of migraines?
	____	____	Do you experience other headaches?
	____	____	Do you have problems with your balance?
Endocrine	____	____	Do you have diabetes?
			What is your most recent HbAlc?_____
	____	____	Do you have thyroid disease?
Psychiatric	____	____	Do you experience depression which is difficult to control?
	____	____	Do you experience anxiety which is difficult to control?
	____	____	Do you have periods of excessive fatigue?

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I AGREE TO RECEIVE CARE IN THIS OFFICE AND ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE.

PATIENT / GUARANTOR SIGNATURE _____ **DATE** _____