

EYECARE ASSOCIATES OF HASLETT/PERRY

Welcome to our office!

DATE _____

PERSONAL INFORMATION

NAME _____ BIRTHDAY _____

SEX M F SS# _____ HOME PHONE _____

ADDRESS _____

WORK PHONE _____ CELL PHONE _____

EMPLOYER _____

OCCUPATION _____

INSURANCE INFORMATION (PLEASE PROVIDE ALL INSURANCE CARDS)

VISION INSURANCE COMPANY _____

POLICY # _____ GROUP # _____

INSURED NAME _____ BIRTHDAY _____

MEDICAL INSURANCE COMPANY _____

POLICY # _____ GROUP # _____

INSURED NAME _____ BIRTHDAY _____

MEDICAL HISTORY

NAME OF FAMILY DOCTOR _____

APPROXIMATE DATE OF LAST PHYSICAL CHECKUP _____

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING?

(CIRCLE ANY THAT APPLY)

ALLERGIES

ASTHMA

ANXIETY

CANCER

DEPRESSION

OTHER _____

DIABETES

EMPHYSEMA

HEART DISEASE

HIGH BLOOD PRES.

HIGH CHOLESTEROL

KIDNEY DISEASE

RHEUM. ARTHRITIS

SARCOIDOSIS

SYSTEMIC LUPUS

THYROID DISEASE

CURRENT MEDICATIONS (LIST RX AND OVER THE COUNTER MEDS INCLUDING EYE DROPS, VITAMINS AND BIRTH CONTROL)

ALLERGIES TO MEDICATIONS (LIST RX AND OVER THE COUNTER)

DO YOU SMOKE OR USE TOBACCO PRODUCTS? YES NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

OTHER SIDE PLEASE

EYE HEALTH HISTORY

IS THERE A FAMILY HISTORY OF THE FOLLOWING?

RELATIONSHIP

BLINDNESS _____
 CATARACTS _____
 CORNEAL PROBLEMS _____
 DIABETES _____
 GLAUCOMA _____
 LAZY EYE _____
 MACULAR DEGENERATION _____
 RETINAL PROBLEMS _____

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING?

(CIRCLE ALL THAT APPLY)

CATARACTS	CORNEAL ABRASION	DRY EYE
EYE INFECTION	EYE INJURY	IRITIS/UVEITIS
LAZY EYE	MACULAR DEGEN.	RETINAL DETACHMENT
OTHER _____		

APPROXIMATE DATE OF LAST EYE EXAM _____

DOCTOR/LOCATION _____

DO YOU CURRENTLY WEAR CONTACT LENSES? YES NO

BRAND OF CONTACTS _____

HAVE YOU EVER TRIED CONTACT LENSES? YES NO

DO YOU WEAR GLASSES? YES NO

DO YOU:

WORK AT A COMPUTER? YES NO

USE PRESCRIPTION SUNGLASSES? YES NO

EXPERIENCE DIFFICULTY WITH GLARE? YES NO

WANT INFORMATION ON LASER VISION CORRECTION? YES NO

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (CIRCLE ANY THAT APPLY)

EYE: DOUBLE VISION, REDNESS, PAIN, BURNING, ITCHING, DISCHARGE,
 LIGHT SENSITIVITY, FLASHING LIGHTS, FLOATERS

NEURO: DIZZINESS, NUMBNESS, TINGLING, LOSS OF BALANCE

GENERAL: FEVER, CHILLS, WEIGHT LOSS, NIGHT SWEATS, TENDER SCALP

SKIN: RASH

HEART: CHEST PAIN, RAPID HEART BEAT

DIGESTIVE: NAUSEA, VOMITING

BLADDER: INCREASED URINARY FREQUENCY

PULMONARY: COUGH, SHORTNESS OF BREATH

MUSCLE: PAIN IN JOINTS, PAIN IN MUSCLES

for office use only. REVIEWED:

____/____/____	____/____/____	____/____/____	____/____/____	____/____/____