EYECARE ASSOCIATES OF HASLETT/PERRY

Welcome to our office! DATE ___________

PERSONAL INFORMATION

NAME ________________________________ BIRTHDAY ______________

SEX M F SS#__________________ HOME PHNE ________________

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	DIABETES	KIDNEY DISEASE
ASTHMA	EMPHYSEMA	RHEUM. ARTHRITIS
ANXIETY	HEART DISEASE	SARCOIDOSIS
CANCER	HIGH BLOOD PRES.	SYSTEMIC LUPUS
DEPRESSION	HIGH CHOLESTEROL	THYROID DISEASE

OTHER ____

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 HEATH 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:

___/___/___	___/___/___	___/___/___	___/___/___	___/___/___

EYE HEATH HISTORY

IS THERE A FAMILY HISTORY OF THE FOLLOWING?

RELATIONSHIP

____ BLINDNESS ____________________

____ CATARACTS ____________________

____ CORNEAL PROBLEMS ____________________

____ DIABETES ____________________

____ GLAUCOMA ____________________

____ LAZY EYE ____________________

____ MACULAR DEGENERATION ____________________

____ RETINAL PROBLEMS ____________________

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__/__/__	__/__/__	__/__/__	__/__/__	__/__/__