Welcome to Family Eyecare

First Name:_____ Address:_____

Last Name:_____ City:_____State:_____ Zip:_____

Date of Birth:_____ Home Phone:_____

SSN:_____ Cell Phone:_____

Gender: ○ Male ○ Female Email:_____

Vision Insurance:_____
Insured ID:_____
Insured Name:_____

Medical Insurance:_____
Insured ID:_____
Insured Name:_____

Employer:_____
Employer Address:_____
_____
Employer Phone:_____

Family Physician:_____

Please list any prescription or over the counter medications you are currently taking:

_____

_____

_____

Please list any allergies to medications you may have:

_____

Please circle any condition for which **you** have been previously treated or diagnosed:

Constitutional: Fatigue Weight Loss Cancer Other:_____

Ears, Nose, Throat: Hearing Loss Sinusitis Dry Mouth Other:_____

Neurological: Multiple Sclerosis Epilepsy Tumor Stroke Migraines Other:_____

Psychological: Depression Anxiety Other:_____

Cardiovascular: Heart Failure High Blood Pressure Heart Attack Stroke Pacemaker Other:_____

Respiratory: Sleep Apnea COPD Asthma Other:_____

Gastrointestinal: Acid Reflux Crohn's Ulcerative Colitis Colon Cancer Other:_____

Genitourinary: Prostate Cancer BPH STD Pregnancy Nursing Other:_____

Muscles/Bones: Arthritis Gout Other:_____

Skin: Cold Sores Shingles Rosacea Acne Other:_____

Endocrine: Diabetes Hyper/Hypo Thyroid Hormone Replacement Therapy Other:_____

Blood: High Cholesterol Anemia Other:_____

Allergic/Immune: Seasonal Allergies Lupus Rheumatoid Arthritis Sjogren's Other:_____

Please circle any eye condition for which **you** have been previously treated or diagnosed:

Retinal Detachment Dry Eye Injury Glaucoma Cataracts Lazy Eye LASIK Macular Degeneration

Other:_____

When was your last comprehensive eye exam?_____

Please circle any condition for which **blood relatives** have been previously treated or diagnosed:

Cancer Diabetes Thyroid High Blood Pressure Heart Disease

Please circle any **eye** condition for which **blood relatives** have been previously treated or diagnosed:

Cataracts Glaucoma Lazy Eye Macular Degeneration Retinal Detachment

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Do you drink alcohol? ○Yes ○No How often?_____

Do you smoke? ○Yes ○No How often?_____ ○ Former Smoker

Please list any hobbies you enjoy:_____

Are you interested in contact lenses?	○Yes ○No
Are you interested in contact lenses that allow you to read up close?	○Yes ○No
Are you interested in hearing about LASIK or other corrective surgeries?	○Yes ○No
Are you bothered by glare?	○Yes ○No
Do your think your glasses are too thick?	○Yes ○No
Do you wear sunglasses outside or do you have Transitions lenses?	○Yes ○No

Is there anything we can do today to make your vision or eye comfort better?

_____

I hereby acknowledge that I have received the right to a copy of the Notice of Privacy Policy from Family Eyecare, which explains the ways in which my personal health information may be used, and my right to access this information.

I give the Doctor permission to treat me as deemed necessary, permission for Family Eyecare to bill my insurance if applicable, and hereby agree to remit payment at the time services are rendered. I also acknowledge that if my insurance information I have provided is incorrect or I am ineligible, I am solely responsible for the associated charges.

Patient/Gardian Signature:_____ Date:_____