EYECARE west

WELCOME TO OUR OFFICE

Patient Name: Last_____ First_____ MI_____ Salutation_____

Address_____ City_____ State_____ Zip_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Soc.Sec.#_____ Driver's License #:_____ Email:_____

Occupation/Grade: _____ Date of Birth: _____ Age: _____ Sex: M F

Employer/School: _____ Employer's Address:_____

Medical Doctor's Name and Group:_____ Last Examination:_____

Spouse/Parent/Guardian Name: _____ Soc.Sec.#:_____ DOB:_____

Occupation: _____ Spouse/Parent/Guardian Employer:_____

In Case of Emergency, Contact:_____ Relationship: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Whom can we thank for referring you to our office?

Please list all insurances, vision and medical.

	Vision Insurance	Primary Medical Insurance	Secondary Medical or Vision Ins.
Ins. Co. Name			
Insured's Name			
Identification No.			
Group No.			
Insured's DOB			
Insured's SS#			
Relation to Insured			

EYEGLASS HISTORY

Do you wear glasses? ☐ Yes ☐ No Full Time Part Time Computer Distance Near (please circle)

Computer Use ☐ Yes ☐ No Hours per day:_____ Distance from computer_____

Glasses owned (please circle): Single Vision, Bifocals, Safety Glasses, Sunglasses, Progressive, Trifocals, Sports Glasses, Computer

Any problems with night vision or glare? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No

Are your sunglasses with your current prescription? ☐ Yes ☐ No

What would you like to do that you can not do with your current prescription? _____

Would you like to be evaluated for refractive laser correction? ☐ Yes ☐ No

CONTACT LENS HISTORY

Do you currently wear contact lenses? ☐ Yes ☐ No

Have you ever worn contact lenses before? ☐ Yes ☐ No Reason for stopping:_____

Do you have back up glasses with the correct prescription? ☐ Yes ☐ No

Answer only if you currently wear contact lenses:

What type? Rigid Gas Permeable Soft Ext Wear Color Brand: _____

How old are your current lenses?_____ How often do you replace them? _____

What solution do you use? _____ Are they comfortable? ☐ Yes ☐ No

PLEASE TURN OVER

MEDICAL HISTORY

Note: Any category left blank will be taken as a "No" response.

EYE HISTORY Do you have any of the following?

blurred vision	☐ Yes	☐ No	excess tearing	☐ Yes	☐ No
double vision	☐ Yes	☐ No	loss of side vision	☐ Yes	☐ No
headaches	☐ Yes	☐ No	dry eyes	☐ Yes	☐ No
floaters/flashes	☐ Yes	☐ No	itching	☐ Yes	☐ No

Do you or anyone in your family have?

	Self	Family	None
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment	☐	☐	☐
Crossed/"lazy" eye	☐	☐	☐
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Color Blindness	☐	☐	☐

List any medications / herbals / over the counter drugs you are taking:	

Allergies to Medications: ☐ Yes ☐ No If yes, explain _____

Any surgeries or major injuries? ☐ Yes ☐ No If yes, explain _____

Are you pregnant and/or nursing? ☐ Yes ☐ No

SOCIAL HISTORY *This information is kept strictly confidential, but is required by some insurance plans. You may discuss this with the doctor if you prefer.*

If yes to any, explain type/amount/how long:

Do you use tobacco products? ☐ Yes ☐ No _____

Do you use illegal drugs? ☐ Yes ☐ No _____

Do you drink alcohol? ☐ Yes ☐ No _____

Have you been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS Many diseases of the body have eye health consequences. Please answer the following:

Do you currently have any of the following problems?

Chronic fever, unexpected weight loss/gain, fatigue?		☐ Yes	☐ No
Ear/nose/throat	(e.g. hearing loss, sinus problems, sore throat)	☐ Yes	☐ No
Heart	(chest pain, irregular beat, swollen feet, cold hands/feet)	☐ Yes	☐ No
Respiratory	(shortness of breath, wheezing, coughing)	☐ Yes	☐ No
Gastrointestinal	(heartburn, abdominal pain, diarrhea, vomiting)	☐ Yes	☐ No
Genitourinary	(painful urination, blood in urine)	☐ Yes	☐ No
Musculoskeletal	(muscle aches, joint pain, swollen joints)	☐ Yes	☐ No
Skin	(rashes, excessive dryness, growths or lumps)	☐ Yes	☐ No
Neurological	(numbness, weakness, headaches, "blackouts")	☐ Yes	☐ No
Psychiatric	(depression, anxiety)	☐ Yes	☐ No
Endocrine	(frequent urination, thirst, feeling hot or cold all the time)	☐ Yes	☐ No
Blood/Lymph	(bruising, weakness, unusual paleness, swollen glands)	☐ Yes	☐ No
Allergy/Immune	(frequent infections, allergic reaction to food, dust, pollen)	☐ Yes	☐ No

Authorization release: I hereby authorize my insurance benefits to be paid directly to Eye Care West Optometry. **I realize I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of this signature on all insurance submissions. I grant permission to contact my physicians and/or school to assist in my care.

Dr. Initials	Date

_____ _____ v.4_06

Patient/Parent/Guardian Signature Date