

Date: _____

Welcome to Advanced Family Eye Care

Patients over 18:

Patient's name _____ Miss Mr. Mrs. Dr. Ms. Rev.

Marital Status (Circle One):

Address _____ M ___ S ___ D ___ W ___

City _____ State _____ Zip _____ Social Security Number _____

Best Phone number to reach you: _____ Home/Cell/Work

(If cell, do you receive text messages? Y N)

Alternate phone number: _____ Home/Cell/Work

(If cell, do you receive text messages? Y N)

E-mail address _____

Who referred you to our office? (Name) _____

Insurance Listing Family Member YellowPages/Online Physician

Patient's date of birth _____ Occupation: _____

Name of Employer: _____ City _____

Name of spouse _____

Please list any members of your household who come to our office:

Who is your family physician? _____

If Patient is a minor, age 18 or younger:

Parent's Names _____

Address if different from

above: _____ City _____ State/Zip _____

Name of parent responsible for account: _____

Parent's Social Security Number: _____

Parent's Occupation _____ Name of Employer _____

PAST, FAMILY AND/OR SOCIAL HISTORY

Name _____

Is there anything in your past history, family history or social history which would help us care for you?

Past History: (illnesses, operations, injuries, medications, treatments) N Y _____

Family History: (diseases, hereditary, risk factors, glaucoma, cataracts lazy eye, macular degeneration, retinal problems, corneal problems) N Y _____

Social History:

What sports/hobbies do you participate in that may have special visual demands? _____

Do you use any of the following ? (please circle which apply)

Tobacco, Alcohol, recreational drugs

Have you ever been exposed to or infected with (please circle which apply)

Gonorrhea, hepatitis, HIV or syphilis

Date of Last Eye Exam:

By Whom?

Do you currently wear glasses or contacts? What kind and when do you wear them?

REVIEW OF SYSTEMS—Do you or have you had any problems with the following?

Eyes	Y	N	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>			
Cornea Problems	<input type="checkbox"/>	<input type="checkbox"/>				Respiratory	Y	N
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	Y	N	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty all the time	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>			
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	Other glands	<input type="checkbox"/>	<input type="checkbox"/>	Current Medications (Rx or Over-the-Counter):		
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	Y	N	_____		
Watery Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Burning or Itching	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	Y	N	_____		
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Chronic Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Halos	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic/Lymphatic	Y	N	Approx Height _____ Weight _____		
Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Medications?		
Retinal problems	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary	Y	N	Any eye surgeries or injuries?		
			Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Allergic/Immunologic	Y	N	Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>				_____		
Medicine allergies	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal	Y	N	Females: Are you pregnant or nursing?		
			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Constitutional Symptoms	Y	N	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Signed (Doctor) & Date:		
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cardiovascular	Y	N				_____		
Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	Y	N	_____		
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>			
			Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Ear, Nose, Mouth, Throat	Y	N						
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	Y	N			
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>			