eyeworks
PATIENT INFORMATION

Today's Date____/___/_____

PERSONAL INFORMATION:

Name:_____Birthdate___/___/_____Age:_____Sex M F

Address:_____City:_____State:_____

Zip:_____Phone:_____SSN:_____

Employer:_____Phone:_____Email:_____

Notify In Case Of Emergency:_____Relationship:_____Phone:_____

Whom may we thank for referring you to our office?_____

May we text you? Yes____ No____

INSURANCE INFORMATION:

Primary Insurance:_____Name of Cardholder**:**_____

ID#_____Cardholder SSN**:**_____

Cardholder Employer:_____Cardholder's DOB____/____/_____

Cardholder's Relationship to Patient:_____

Secondary Insurance:_____Name of Cardholder**:**_____

ID#_____Cardholder SSN**:**_____

Cardholder Employer:_____Cardholder's DOB____/____/_____

Cardholder's Relationship to Patient:_____

RESPONSIBLE PARTY'S INFORMATION: (IF A MINOR)

Name:_____Relationship to Patient:_____

Address:_____City:_____State:_____Zip:_____

Employer:_____Work Phone:_____

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MEDICAL HISTORY RECORD

OCULAR HISTORY:

Do you currently wear glasses? Y N If NO, have you worn glasses in the past? Y N
Do you currently wear contacts? Y N If NO, have you worn contacts in the past? Y N

Have you had any eye injuries or surgeries in the past? Date:_____R or L eye ____
Surgeon:_____Reason for surgery:_____

Have you been previously diagnosed with any of the following ocular conditions?

Amblyopia (lazy eye)	Y N	Cataracts	Y N
Strabismus(turned eye)	Y N	Macular Degeneration	Y N
Glaucoma	Y N	Dry Eyes	Y N
Blindness	Y N	Other:_____	

FAMILY HISTORY:

Does anyone in your family have any of the following conditions?
(**M**=Mother, **F**=Father, **B**=Brother, **S**=Sister, **GM**=Grandmother, **GP**=Grandfather)

Lazy Eye Y N_____	Glaucoma Y N_____	Diabetes Y N_____
Blindness Y N_____	Macular Degeneration Y N_____	High Blood
Cataract Y N_____	Retinal Detachment Y N_____	Pressure Y N_____

MEDICAL HISTORY:

Do you presently have, or have you in the past had, any problems in the following areas? (Explain)

Ear, Nose, Throat, or Mouth	Y N	_____
Cardiovascular (Heart/Blood Pressure)	Y N	_____
Endocrine (Diabetes/Thyroid/Cholesterol)	Y N	_____
Gastrointestinal (Stomach/Intestines)	Y N	_____
Genitourinary (Kidney/Bladder)	Y N	_____
Respiratory (Lungs/Breathing)	Y N	_____
Musculoskeletal (Muscles/Bones)	Y N	_____
Integumentary (Skin/Breast)	Y N	_____
Neurological (Seizures/Migraines)	Y N	_____
Psychiatric (Depression/Bipolar, Etc.)	Y N	_____
Do you have any history of cancer?	Y N	What type and year_____
Allergies (Environmental/Animals, Etc.)	Y N	_____
Are you allergic to any medications?	Y N	Please list_____
Do you have any other illnesses?		_____

Please continue →

Family Doctor:_____City:_____Phone:_____

CURRENT MEDICATIONS: (Prescription & OTC medications and any eye drops used). Attach list if necessary

Name of medication	For what condition?	Dosage
1.		
2.		
3.		
4.		
5.		

SOCIAL HISTORY:

Do you drive? Y N
Do you smoke? Y N How many packs a day? _____
Do you drink alcohol? Y N How many glasses a day? _____
Do you use illegal drugs? Y N
In what order were you born? 1st 2nd 3rd 4th 5th Identical Twin Fraternal Twin
What is your occupation? _____
Does your employer require safety glasses? Y N
What are your hobbies? _____

Name of person completing this form (if other than patient): _____
Relationship to patient: _____