EYE CONSULTANTS, P.C.

# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

## PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employment ☐ Full Time ☐ Part Time

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Phone numbers:

Home ( _____ ) _____

Cell ( _____ ) _____

Day Phone ( _____ ) _____

In case of an emergency contact:
(Specify someone who does not live in your household.)

Name _____ Relationship _____

Home ( _____ ) _____

Work Phone ( _____ ) _____

Cell ( _____ ) _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by vision insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

*Please see Financial Policy for specifics regarding insurance.

Group # _____

## EYE HEALTH HISTORY

Date of last eye exam _____

Eye physician _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally
☐ Reading ☐ Driving ☐ TV

Previous eye surgery? ☐ Yes ☐ No

_____

Do you wear contacts? ☐ Yes ☐ No

Type_____ Hours/Day _____

Describe any problems you have with your contacts _____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Bloodshot Eyes | ☐ Yes ☐ No | | Floaters or Spots | ☐ Yes ☐ No | |
| Blurred Vision – Distance | ☐ Yes ☐ No | | Glaucoma | ☐ Yes ☐ No | |
| Blurred Vision – Near | ☐ Yes ☐ No | | Headaches | ☐ Yes ☐ No | |
| Burning Eyes | ☐ Yes ☐ No | | Itching Eyes | ☐ Yes ☐ No | |
| Cataracts | ☐ Yes ☐ No | | Light Sensitive | ☐ Yes ☐ No | |
| Color Vision, Poor | ☐ Yes ☐ No | | Loss of Vision | ☐ Yes ☐ No | |
| Crossed Eyes | ☐ Yes ☐ No | | Migraine Headaches | ☐ Yes ☐ No | |
| Discharge from Eyes | ☐ Yes ☐ No | | Night Vision, Poor | ☐ Yes ☐ No | |
| Dizzy Spells | ☐ Yes ☐ No | | Red Eyes | ☐ Yes ☐ No | |
| Double Vision | ☐ Yes ☐ No | | Seeing Halos | ☐ Yes ☐ No | |
| Dry Eyes | ☐ Yes ☐ No | | Seeing Flashes | ☐ Yes ☐ No | |
| Eye Infection | ☐ Yes ☐ No | | Temporary Loss of Vision | ☐ Yes ☐ No | |
| Eye Injury | ☐ Yes ☐ No | | Twitching Eyelid | ☐ Yes ☐ No | |
| Eye Strain | ☐ Yes ☐ No | | Vision Poor | ☐ Yes ☐ No | |
| Fainting Spells, Blackouts | ☐ Yes ☐ No | | Watering Eyes | ☐ Yes ☐ No | |

## MEDICATIONS

List any medications you are currently taking, including eye drops:

_____

_____

Pharmacy Name _____

Phone (_____) _____

## ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

# HEALTH HISTORY

**Primary Care Physician** _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

| | Yourself | | Family Members | | | Yourself | | Family Members | |
|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Hepatitis (Type_____) | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Arthritis | ☐ Yes | ☐ No | ☐ Yes | ☐ No | High Blood Pressure | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Artificial Heart Valve | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Kidney Disease | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Artificial Joints | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Lazy Eye | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Lupus | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Bleeding | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Macular Degeneration | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Blindness | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Migraine Headaches | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Pacemaker | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Poor Color Vision | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Chemical Dependency | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Retinal Disease | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Rheumatic Fever | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Drug Sensitivity | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Shingles | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Emphysema | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Skin Conditions | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Eye Surgery | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Thyroid Conditions | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Tuberculosis | ☐ Yes | ☐ No | ☐ Yes | ☐ No |
| Hay Fever | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Are you pregnant? _____ | Number of children_____ | | | |
| Heart Condition | ☐ Yes | ☐ No | ☐ Yes | ☐ No | Tobacco use _____ | Alcohol use_____ | | | |

# LIFESTYLE QUESTIONNAIRE

**HELP US HELP YOU.** In order for our doctors to assist you in making the best possible decisions about your vision and general eye health, please take a moment to complete this section, which is designed to indicate what eye health options might be right for you. *Thank you.*

1. What recreational hobbies or activities do you enjoy? Check all that apply.
   - ☐ Golf ☐ Running ☐ Racquetball ☐ Football
   - ☐ Tennis ☐ Snow Skiing ☐ Baseball/Softball ☐ Boating
   - ☐ Water Sports ☐ Fishing ☐ Basketball ☐ Other _____

2. What interests and hobbies do you enjoy? Check all that apply.
   - ☐ Reading ☐ Gardening ☐ Knitting ☐ Crafts
   - ☐ Watching TV ☐ Cooking ☐ Video Games ☐ Painting
   - ☐ Internet ☐ Sewing ☐ Woodworking ☐ Other _____

3. What job requirements do you have? Check all that apply.
   - ☐ Computer Work ☐ I Work Outdoors
   - ☐ Considerable Reading ☐ My Job Necessitates Safety Eyewear
   - ☐ I Work Under Fluorescent Lighting ☐ Other _____

4. Are you experiencing any difficulties with your glasses and/or contact lenses with these activities? Check all that apply.
   - ☐ Glare ☐ Inconsistent Vision
   - ☐ Fogging ☐ Other: _____
   - ☐ Constant Adjustment _____

5. Are your lenses scratched or damaged from regular use? ☐ Yes ☐ No
6. Do you spend more than two hours a day viewing a computer screen? ☐ Yes ☐ No
7. Do you consider yourself sensitive to sunlight? ☐ Yes ☐ No
8. Do you spend more than one hour a day in the sun? ☐ Yes ☐ No
9. Do you have difficulties driving at night? ☐ Yes ☐ No
10. Are your current glasses uncomfortable or cause indentations on your nose? ☐ Yes ☐ No
11. Would thinner lighter lenses appeal to you? ☐ Yes ☐ No
12. Would you like a frame style change? ☐ Yes ☐ No

List "designer" labels you include in your wardrobe.

_____ _____

_____ _____

14. Which statement(s) best describe yourself?
   - ☐ I lead an active lifestyle (exercise and recreation). ☐ I try to keep up with the later fashion trends.
   - ☐ I enjoy being outdoors as much as possible. ☐ I am allergic to nickel products.