Welcome To Primary Eyecare Associates

To ensure proper care, our doctors and many insurance companies require a comprehensive medical health and visual history from all patients as part of the eye examination. Thank you for the privilege of allowing us to be of service to you and your family, and thank you for your cooperation.

Name ____ Today's Date: ____________
Street Address ____ City/State/Zip ______________________
Preferred Contact Phone Number: ______________________ Cell ❑ Home ❑ Work ❑ Can we text ▢ Yes ▢ No
E-Mail Address: ________________________ Date of Birth:____/____/_____ Age: ____ Sex: M/F Marital Status___
Employer/Occupation: ______________________________ School Grade or year (if attending): _______________
For children, Mother's name: _________________________ Father's name: ____________________________
Local person & phone number to notify in case of emergency: ______________________________________
Last Eye Exam: ___/___/___ Name/Location of your last eye doctor: _____________________________________
Last Medical Exam: ___/___/___ Name & # of your doctor: ___________________________ Is this your PCP? ▢ Yes ▢ No

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Vision and Medical Insurance Information:
Policy Holder's Name____ Date of Birth:___/___/____
Insurance Policy #:Medical:____________________ Vision: ___________________
Name of Insurance: Medical___________________________ Vision___________________________________

Ocular History:
Have you ever had an eye injury, eye operation, or serious eye infection? If so,_______________________________
____
List below any ocular concerns or conditions that you may have (ex: Dry eyes, flashes/floaters, tired eyes, droopy eyelid)
____
____
Do you wear glasses? ▢ Yes ▢No If yes, how old are your glasses?__________ Do you wear sunglasses? ▢Yes ▢ No
Have you had LASIK (laser vision correction) ? Yes__ No__ If yes, Date___/___ Are you interested in LASIK? ▢ Yes No ▢
Do you wear contact lenses? ▢ Yes ▢No If yes, how old is your present pair?__________________________
If No, are you interested in contact lenses? ▢ Yes ▢ No
Type of contact lenses: ▢Rigid/Hard ▢Soft ▢Extended Wear ▢ Disposable ▢Other Are they comfortable? ▢ Yes ▢ No
If disposable how often do you dispose of them? ▢ 1-2 Weeks ▢1 Month ▢2 Month ▢3 Month ▢Other__________

Medical History: Do you take any medications?▢ Yes ▢No If yes, please list all medicines including oral contraceptives, vitamins and OTC's: ____
____
Do you have any seasonal or medicine allergies? ▢ Yes ▢No If yes, please explain: __________________________
____
____
List all major injuries, surgeries or hospitalizations: ____
____
____
Women: Are you pregnant? ▢ Yes ▢No If yes, what is your due date? ________________ Are you nursing? ▢ Yes ▢No

<u>Social History: This information is kept strictly confidential.</u>

Do you have difficulty adjusting to the dark? ▢ Yes ▢No Please explain____________________________________

____

Do you drive?▢ Yes ▢No Do you have visual difficulty driving?▢ Yes ▢No If yes, please explain below

____

Do you use tobacco products? ▢ Yes ▢No Do you drink alcohol? ▢ Yes ▢ No

Do you use illegal drugs?▢ Yes ▢No Have you been exposed to or infected with: ▢HIV ▢Hepatitis ▢No

Personal and Family Eye History: Do you or does anyone in your immediate family have a history of the following?

	Self	Family	Describe / Who		Self	Family	Describe / Who
Dry/Scratchy Eyes	▢	▢	______	Glaucoma	▢	▢	______
Macular Degeneration	▢	▢	______	Retinal Detachment	▢	▢	______
Double Vision	▢	▢	______	Blindness	▢	▢	______
Tearing /Watery Eyes	▢	▢	______	Loss of Vision	▢	▢	______
Flashes / Floaters	▢	▢	______	Stye/Chalazion	▢	▢	______
Redness or Mucous	▢	▢	______	Chronic Infection	▢	▢	______
Eye Pain or Soreness	▢	▢	______	Crossed / Lazy Eye(s)	▢	▢	______

Have you ever had a concussion? Explain. ____

Have you had any eye injuries or surgeries? ▢ Yes ▢No If yes, explain:____

____

Personal / Family Health History and Review of Symptoms: Do you or does anyone in your immediate family have a history of the following? <u>PLEASE CIRCLE the conditions that apply.</u>

	No	Self	Family / Who
Neurologic (headaches, migraines, seizures, MS)	▢	▢	______
Blood, lymphatic (high cholesterol, anemia, hepatitis, bleeding)	▢	▢	______
Ear, nose, throat (sinus, ear infections, dry mouth, chronic cough)	▢	▢	______
Cardio-vascular (heart, high blood pressure, vascular disease)	▢	▢	______
Gastro-intestinal (stomach ulcers, diarrhea, constipation)	▢	▢	______
Bones, joints, muscles (arthritis, osteoporosis, chronic fatigue)	▢	▢	______
Allergic or immunologic (lupus, sarcoid)	▢	▢	______
Genito-urinary (kidney, bladder, prostate)	▢	▢	______
Endocrine (diabetes, thyroid or other glands)	▢	▢	______
Respiratory (asthma, emphysema, bronchitis)	▢	▢	______
Skin (acne, warts, skin cancer, keloid formation)	▢	▢	______
Constitutional (Fever, weight loss / gain)	▢	▢	______
Other ______________________________	▢	▢	______

If you answered YES to any of the above, please explain: ____

____

____

Whom may we thank for referring you or how did you hear of us?: ____

Patient Signature:_______________________________ Date:__________________

DISCLAIMER: By typing your name above, you are signing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.