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.

Once completed please email to primaryeyecare@pecavision.com or fax to 703-272-7955.

Name: Today's Date:

Address: E-Mail Address:

Preferred Contact Phone Number: ☐ Cell ☐ Work ☐ Home May we send texts? ☐ Yes ☐ No

Date of Birth: Sex 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 doctor: Is this your PCP? ☐ Yes ☐ No

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Insurance Information: Policy Holder's Name Date of Birth:

SSN:

Medical Insurance Name and Policy #:

Vision Insurance Name and Policy #:

Ocular History:

Have you ever had an eye injury, eye operation, or serious eye infection? Please describe:

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 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 ☐ Soft ☐ Extended Wear ☐ Disposable ☐ Other re they comfortable? ☐ Yes ☐ No

If disposable how often do you dispose of them? ☐ Daily ☐ 1-2 Weeks ☐ 1 Month ☐ 2 Month ☐ 3 Month

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

Social History: This information is kept strictly confidential.

Do you drive? ☐ Yes ☐ No Do you have visual difficulty driving? ☐ Yes ☐ No If yes, please describe 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?

Cataracts: ☐ No ☐ Self ☐ Family - Who: Crossed/Lazy Eyes: ☐ No ☐ Self ☐ Family - Who:

Glaucoma: ☐ No ☐ Self ☐ Family - Who: Dry/Scratchy Eyes: ☐ No ☐ Self ☐ Family - Who:

Ret Detachment: ☐ No ☐ Self ☐ Family - Who: Macular Degeneration: ☐ No ☐ Self ☐ Family - Who:

Blindness: ☐ No ☐ Self ☐ Family - Who: Double Vision: ☐ No ☐ Self ☐ Family - Who:

Loss of Vision: ☐ No ☐ Self ☐ Family - Who: Tearing/Watering: ☐ No ☐ Self ☐ Family - Who:

Light Sensitivity: ☐ No ☐ Self ☐ Family - Who: Flashes or Floaters: ☐ No ☐ Self ☐ Family - Who:

Stye/Chalazion: ☐ No ☐ Self ☐ Family - Who: Redness or Mucous: ☐ No ☐ Self ☐ Family - Who:

Chronic Infection: ☐ No ☐ Self ☐ Family - Who: Eye pain or Soreness: ☐ No ☐ Self ☐ Family - Who:

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? Please check all that apply & indicate 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 / Other Glands Respiratory: ☐ Asthma ☐ Emphysema ☐ Bronchitis

Skin: ☐ Acne ☐ Warts ☐ Skin Cancer ☐ Keloid Formation Constitutional: ☐ Fever ☐ Weight Loss / Gain

Other / Explanation:

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

Patient Signature:

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.