Welcome To Primary Eyecare Associates

To insure 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❑

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_ Sex: M/F Marital Status\_\_\_

Employer/Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Grade or year (if attending): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of family members living at home:

 Name: 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_ Patient Here? Yes \_\_ No \_\_ 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_ Patient? Y\_\_ N\_\_

 Name: 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_ Patient Here? Yes \_\_ No \_\_ 4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_ Patient? Y\_\_ N\_\_

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? Y\_\_N\_\_

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**Vision and Medical Insurance Information**: Policy Holder's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_/\_\_\_/\_\_\_\_

SSN:\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_ Insurance Policy #:Medical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance: Medical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Ocular History:**

Have you ever had an eye injury, eye operation, or serious eye infection? If so,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List below any ocular concerns or conditions that you may have (ex: Dry eyes, flashes/floaters, tired eyes, droopy eyelid) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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\_\_ past \_\_\_ 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\_\_\_ Are they comfortable? Yes\_\_ No\_\_

If disposable how often do you dispose of the? 1-2 Weeks\_\_\_ 1 Month\_\_\_ 2 Month\_\_\_ 3 Month\_\_\_ Other\_\_\_\_\_\_\_\_\_\_

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**Medical History**: Do you take any medications? No\_\_\_ Yes\_\_\_ If yes, please list all medicines including oral contraceptives,

vitamins and OTC's: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any seasonal or medicine allergies? No\_\_\_ Yes\_\_\_ If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List all major injuries, surgeries or hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Women: Are you pregnant? Yes \_\_\_ No\_\_\_ If yes, what is your due date? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you nursing? Y\_\_\_ N\_\_\_

**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?

 No Self Family Describe briefly No Self Family Describe briefly

Cataracts \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Crossed/Lazy Eyes \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry/Scratchy Eyes \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ret Detach \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Macular Degen \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Double Vision \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Vision \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tearing/Watering \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Light Sens \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flashes or Floaters \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stye/Chalazion\_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Redness or Mucous \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Infec \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye pain or Soreness \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Personal / Family Health History and Review of Symptoms:** Do you or does anyone in your immediate family have a

history of the following? PLEASE CIRCLE the conditions that apply.

 No Self Family

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_