EVERY EYE CARE

Date:____________________

Check if this applies to you:

☐ Glaucoma

☐ Diabetic

Mr. Miss Mrs.

Male Female

First Name	MI	Last Name

Street Address	City	State	Zip Code

Social Security	Date of Birth	Age	Email Address

Home Phone	Work Phone	Cell Phone

How will you settle your account today? CASH CHECK CREDIT CARD CARE CREDIT

Vision Insurance:________________________________

Subscribers Name:________________________________

Subscribers SSN:________________________________

Subscribers DOB:________________________________

Medical Insurance:________________________________

Subscribers Name:________________________________

Subscribers SSN:________________________________

Subscribers DOB:________________________________

Date of last exam?________________________________

Have you ever tried contact lenses? YES / NO

Do you currently wear contact lenses? YES / NO

Brand of contacts?________________________________

Solutions used?________________________________

If you wear bifocals, do the lines or head tilting bother you? YES / NO

Any problems with your current contact lenses or eyeglasses? YES / NO If yes, please explain:____________________

____

What is the major purpose of this visit?________________________________

Every Eye Care is dedicated to promoting education and knowledge to you about your eye health and unique vision needs. We are committed to providing high quality, personalized eye care in a friendly and professional manner. Our services and products will be delivered with integrity, honesty, and compassion.

Date of last physical checkup?______________________________

Date of last eye exam?______________________________

Name of Family Physician?______________________________

Current medications?______________________________

____

Allergies to any medications? YES / NO

If YES, what medications?______________________________

Have you had any surgeries?______________________________

If YES, list:______________________________

Do you use cigarettes, tobacco, alcohol, or substances? YES / NO

If YES, list:______________________________

Do you...(check if the answer is YES)

- ☐ Work on the computer? How many hours? _______ hrs. per day.
- ☐ Think you might benefit from thinner, lighter lenses?
- ☐ Spend time outdoors? How much? _______ hrs/wk
- ☐ Have prescription sun wear?
- ☐ Prefers not to war your glasses at times?
- ☐ Have Children?
- ☐ Have family members in need of eyewear?

Is there a family medical history of any of the following (if yes, check and tell who)

☐ Blindness ____________	☐ High Blood Pressure____________
☐ Cataracts____________	☐ Heart Disease____________
☐ Corneal Problem____________	☐ Lazy Eye____________
☐ Diabetes____________	☐ Macular Degeneration ____________
☐ Glaucoma____________	☐ Retinal Problems____________

Have you ever experienced, been diagnosed or treated for any of the following? (If yes, check)

☐ Macular Degeneration	☐ Glaucoma	☐ Cataracts	☐ Retinal Detachment
☐ Floaters / Spots	☐ Blurry Vision	☐ Double Vision	☐ Itchiness
☐ Flashes of Light	☐ Tearing	☐ Burning	☐ Corneal Abrasions
☐ Sunlight Sensitivity	☐ Iritis / Uveitis	☐ Eye Injury	☐ Trouble seeing at night
☐ Occasional Dryness	☐ Eye Infections	☐ Lazy Eye	☐ Headaches
☐ Crossed eye / Eye turn	☐ Grittiness	☐ Other eye disorder ____________	

Have you ever been diagnosed or treated for the following health problems/ (if yes, check)

☐ Allergies	☐ Arthritis	☐ Blood / Lymph	☐ Cancer
☐ Cholesterol	☐ Diabetes	☐ Endocrine	☐ Ears / Nose / Throat
☐ Eczema / Rash	☐ Fevers	☐ Genitourinary	☐ High Blood Pressure
☐ Integumentary (skin)	☐ Kidney	☐ Muscle / Bone	☐ Psychological
☐ Respiratory	☐ Sinus	☐ Thyroid	☐ Throat Infections
☐ Fatigue	☐ Digestive	☐ Bronchitis	☐ Neurological
☐ Unusual weight loss / gain	☐ Cancer if yes, specify;____________		

Very Important!!! NEW PATIENTS ONLY: Who may we thank for referring you to our office?

Friend or Relative____________ if not referred, how did you choose our office?

☐ Another Doctor ☐ Insurance list ☐ Sign / Building ☐ Website

☐ Newspaper / Radio / TV ☐ Other:____________