Premier Eye Care

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced / Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: ( ) _____

Preferred Language _____ Race: _____ Ethnicity: _____ Communication Preference:

___Telephone ___Postal ___ E-mail Referred by: _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Sometimes Work Only Reading only Driving only

How old are your present glasses? _____ Do you wear prescription Sun Wear: Yes No

Do you wear contact lenses? Yes No Type:_____ Solution Used: _____

Wearing schedule: **Daily** **Overnight** Replacement schedule: **Daily** **2 week** **Monthly** **Yearly**

Have you ever had an eye injury? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Are you currently using eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneration: Yes No When were you diagnosed?_____

Do your eyes ever feel dry or uncomfortable? Yes No

Are you bothered by changes in your vision throughout the day? Yes No

Are you ever bothered by red eyes? Yes No

Do you ever use or feel the need to use rewetting eye drops? Yes No

What are your visual symptoms (with correction): Please circle any that apply and indicate Right, Left or Both:

Blurred Vision/Distance	R L B	Itchy Eyes	R L B	Headaches	R L B
Blurred Vision/Near	R L B	Watery Eyes	R L B	Light Sensitive	R L B
Double Vision	R L B	Crossed Eyes	R L B	Poor Color Vision	R L B
Eye Strain	R L B	Wandering eye	R L B	Poor Night Vision	R L B
Eye Pain/Soreness	R L B	Mucus Discharge	R L B	Droopy Lid	R L B
Loss of Vision	R L B	Floaters or Spots	R L B	Flashes	R L B

Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ **None**	**Endocrine:** ___ **None**	**Respiratory:** ___**None**
___ Hypertension	___ Non-Insulin Dependent Diabetes	___ Asthma
___ Stroke	___ Insulin Dependent Diabetes	___ Bronchitis
___ Heart Disease	___ Thyroid Problem	___ Emphysema
___ Vascular Disease	___ Hormonal Dysfunction	___ COPD
___ Elevated Cholesterol	___ Other:	___ Sleep Apnea
___ Other:		___ Other:
Constitutional: __ **None**	**Ocular** __ **None**	**Psychiatric:** __ **None**
___ Fever/Weight gain/loss	___ Glaucoma	___ ADHD/ADD
___ Weakness/Fatigue	___Macular Degeneration	___ Depression
___ Increase of thirst/urination	___Detached Retina	___ Schizophrenia
___ Other:	___ Other:	___ Other:
Neurological: __ **None**	**Musculoskeletal:** __ **None**	**Immunologic:** __ **None**
___ Multiple Sclerosis	___ Osteoarthritis	___ AIDS or HIV
___ Epilepsy	___ Fibromyalgia	___ Rheumatoid Arthritis
___ Cerebral Palsy	___ Muscular Dystrophy	___ Lupus
___ Tumor	___ Ankylosing Spondylitis	___ Neurofibromatosis
___ Migraine ___ Other:	___ Other:	___ Other:
Hematological: __ **None**	**Gastrointestinal** __ **None**	**Ear/Nose/Throat:** __ **None**
___ Anemia	___ Crohn's	___ Hearing Loss
___ Leukemia	___ Colitis	___ Upper Respiratory Infection
___ Other:	___ Acid Reflux ___ Other:	___ Other:
Dermatologic: __ **None**	**Allergies** (please list) __ **None**	
___ Eczema	Drug:	**Alcohol Use:** **Y** **N**
___ Rosacea		Amount:
___ Psoriasis ___ Skin Cancer	Environmental:	**Tobacco Use:** **Y** **N**
___ Other		**Amount:** **Quit:** ____

Surgeries (type & dates): _____

Please list any medications and/or drugs that you are taking (including OTC supplements) : See Attached List: _____

1	**For**	**6**	**For**
2	**For**	**7**	**For**
3	**For**	**8**	**For**
4	**For**	**9**	**For**
5	**For**	**10**	**For**

FAMILY HISTORY: Has anyone in your immediate family (parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION			
High Blood Pressure:		Yes No Cataracts:	
Yes No			
Diabetes:		Yes No Glaucoma:	
Yes No			
Cancer:		Yes No Macular Degeneration:	
Yes No			
Thyroid Disease:	Yes No	Retinal Detachment:	Yes No