WELCOME TO OUR OFFICE

Patient Information

Date ______________________________

Last ______________________________

First ______________________ MI _______

Street ______________________________

City ______________________________

State ____________ Zip Code ___________

Home Phone ________________________

Work Phone ________________________

Patient's SSN ______________________

Email Address ______________________

Date of Birth ________________ Age _______

Occupation (or Grade) _________________

Gender: ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Employer (or School) __________________

Spouse (or Parent's Name) ______________

Spouse (or Parent's Work) ______________

What is the major purpose of this visit?

____

Any problems with your current contact lenses or glasses?______________________________

____

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

Name of friend or relative:_________________
If not referred, how did you choose our office?

❑ Another Dr.

❑ Insurance List

❑ Saw Sign/Building

❑ Newspaper/Radio/TV

❑ Yellow Pages: Which Directory? ___________

❑ Web Page: Which Web Site? ___________

❑ Other ______________________

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance______________________
Subscriber Name______________________
Subscriber SSN______________________
Subscriber Birth Date______________________

Primary Medical Insurance______________________
Subscriber Name______________________
Subscriber SSN______________________
Subscriber Birth Date______________________

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer? If yes, please complete computer questionnaire.

❑..think you might benefit from thinner, lighter lenses?

❑..spend time outdoors? How much? __Hrs/week

❑..have prescription sunwear?

❑..prefer not to wear your glasses at times?

❑..want information on Laser Vision Correction surgery?

❑..have more than 1 pair of current Rx eyewear?

❑..have children?

❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Other eye disorders______________________
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician___________________________

Town___________________________

Date of Last Visit___________________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)___________________________

____

____

Allergies to medications? ❑ Yes ❑ No

If so, what medications?___________________________

____

Have you had any surgeries? ❑ Yes ❑ No

If yes, what surgeries? ___________________________

____

Do you use cigarettes? ❑ Yes ❑ No

If yes, packs per day? ______________

Do you drink alcohol? ❑ Yes ❑ No

If yes, how many drinks per week? ____________

Do you take illegal drugs? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam ___________________________

By Whom? ___________________________

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind?___________________________

Solutions used___________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Are you interested in learning more about LASIK and other vision correction surgery? ❑ **Yes** ❑ **No**

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑ ________________
Cataracts	❑ ________________
Corneal Problems	❑ ________________
Diabetes	❑ ________________
Glaucoma	❑ ________________
Heart Disease	❑ ________________
Lazy Eye	❑ ________________
Macular Degeneration	❑ ________________
Retinal Problems	❑ ________________
High Blood Pressure	❑ ________________

Our mission at Complete Family Eyecare is to contribute to a lifetime of healthy vision for all of our patients. Through the care we provide, we are committed to the visual needs, wellness, and improved quality of life for our patients. Continuing education will remain at the forefront of our priorities to ensure we offer the latest eye care, technology and products. Our staff is dedicated to providing you with the highest level of care as we grow together.