Elkton Eyecare

## PERONAL INFORMATION

Today's Date_____

Patient Name: _____ Date of Birth _____/_____/_____ M / F Age:_____

Address: _____
(Street / apt #) (City) (State) (ZIP)

Phone: Home: ( ) - Cell: ( ) - Work: ( ) -

Email: _____

Occupation: _____ Employer / School: _____ Payment: Visa / MC Cash Check

Responsible party / parent / guardian (if patient is a child): _____

Responsible party's address / phone: _____
(Street / apt #) (City) (State) (ZIP) (phone number)

Where did you hear about us? Flyer Newspaper Radio Internet From a Friend (name of friend_____)

## EYE HEALTH AND VISION QUESTIONNAIRE

What is the main reason for your visit today?_____
When was your last eye exam?_____Name of Doctor_____
Please list any previous eye injures or surgeries_____
Do you have more than one pair of current rx eye glasses? Y N
Are you interested in refractive surgery, including LASIK? Y N
Are you interested in a contact lens prescription today? Y N
If so, what type?: Disposable Gas Permeable For Astigmatism Bifocal Color Unsure
If you are a contact lens wearer, please answer the following questions:
How long do you use each pair of your lenses?_____
If anything, what do you dislike most about your current lenses?_____
Do you sleep in your lenses? Y N
Please let us know what you are currently wearing (if known):

| | BRAND | POWER | BASE CURVE | DIAMETER |
|---|---|---|---|---|
| RIGHT EYE | | | | |
| LEFT EYE | | | | |

Do you experience, or have you recently experienced:

- ❑ Blurry vision
- ❑ Burning
- ❑ Tearing
- ❑ Grittiness
- ❑ Itching
- ❑ Poor night vision
- ❑ Headaches
- ❑ Crossed eyes / eye turn
- ❑ Double vision
- ❑ Flashes of light
- ❑ Floaters / spots
- ❑ Problems with glare

Have you or has anyone in your family been diagnosed with:

| | **Self** | **Family, Who?** |
|---|---|---|
| Cataracts | ❑ | ❑ |
| Glaucoma | ❑ | ❑ |
| Macular degeneration | ❑ | ❑ |
| Lazy Eye (Amblyopia) | ❑ | ❑ |
| Iritis / Uveitis | ❑ | ❑ |
| Retinal detachment | ❑ | ❑ |
| Other_____ | ❑ | ❑ |

## MEDICAL HISTORY

Primary care physician:_____

Are you allergic to any medications? YES NO If YES, please list: _____

Please list any prescription or over the counter medications you are currently taking:_____

_____

Are you pregnant or nursing? YES NO

Do you smoke? YES NO If Yes, how much?_____

Do you drink alcohol? YES NO If Yes, how much?_____

Do you use illegal drugs? YES NO if Yes, please explain:_____

## REVIEW OF SYSTEMS

Do you or does anyone in your immediate family have any of the following health problems?

If YES, please specify

| | **Self** | **Family, Who?** | | **Self** | **Family, Who?** |
|---|---|---|---|---|---|
| Diabetes | ❑ | ❑ | Cholesterol | ❑ | ❑ |
| High blood pressure | ❑ | ❑ | Thyroid | ❑ | ❑ |
| Heart disease / Stroke | ❑ | ❑ | Cancer | ❑ | ❑ |
| Respiratory / Asthma | ❑ | ❑ | Urinary | ❑ | ❑ |
| Kidney disease | ❑ | ❑ | Skin | ❑ | ❑ |
| Arthritis | ❑ | ❑ | Blood / Lymph | ❑ | ❑ |
| Gastrointestinal | ❑ | ❑ | OTHER_____ | ❑ | ❑ |

## HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented Elkton Eyecare's Notice of Privacy Policy and have been offered a copy for my records:

Signature:_____ Date:_____

**Payment is due at time services are rendered**

Comments / Suggestions: