Eastern Eye Associates
OPTOMETRISTS

WELCOME TO OUR OFFICE

Thank you for selecting our office for your eye care needs. We strive to provide the highest level of care to you and your family. Our doctors and staff enjoy serving patients of all ages--from young children with lazy eyes, to adults with special visual needs, to senior citizens with glaucoma and cataracts. With the support of the ophthalmic surgeons at our referral centers, we believe our office is one of the finest eye care practices in Virginia.

Patient Name: _____ Sex: M ___ F ___ Birth Date: _____/_____/_____

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

Home Phone: _____ Work Phone: _____ Mobile Phone: _____
Social Security #
(if required for insurance): _____ Marital Status: _____ Email Address: _____
Date of Last
Eye Exam: ____/____/____ Last Eye Doctor: _____ How did you hear about our office? _____

Employer & Occupation: _____ Name of Responsible Party: _____

Insurance (Primary): _____ Insurance (Secondary):_____

Policy Holder Information (if different from Patient):

Name: _____ Social Security #: _____-_____-_____ Birth Date: _____/_____/_____

Family Information
Our office focus is on family care. Therefore, we like to keep family records together, please list family members that are part of your household.

Name	**Relationship**		**Examined here before?**
_____	Birth date	_____/___/____	Yes ☐
_____	Birth date	_____/___/____	Yes ☐
_____	Birth date	_____/___/____	Yes ☐

Family History
Please note any family history [mother (M), father (F), grandmother (GM), grandfather (GF), brother (B), sister (S), and/or child/children (C), living or deceased] for the following:

DISEASE/CONDITION	YES	NO	UNKNOWN	RELATIVE(S)		YES	NO	UNKNOWN	RELATIVE(S)
Blindness	☐	☐	☐	_____	Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____	Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____	Retinal Disease/				
Arthritis	☐	☐	☐	_____	Detachment	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____	Cancer	☐	☐	☐	_____
HighBlood Pressure	☐	☐	☐	_____	Heart Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____	Kidney Disease	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____					

NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy or have been offered a copy of Eastern Eye Associates' Notice of Privacy Practices.

Signature: _____ Date: _____

Relationship to patient: _____

Medical History

Family Doctor: ______________________________________ Last Medical Exam: ______/______/______

Do you have any allergies to medications? NO ☐ YES ☐ If yes, explain: ____

____

List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies): __________________

____

List all major injuries, surgeries and/or hospitalizations you have had: ____

____

List any of the following that you have had: crossed eyes, lazy eye, eye surgery, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injuries? ____

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain below)

EYES	**YES**	**NO**	**UNKNOWN**
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Sties or Chalazions	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired eyes	☐	☐	☐
EAR, NOSE, MOUTH AND THROAT			
Allergies	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐

VASCULAR	**YES**	**NO**	**UNKNOWN**
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY	☐	☐	☐
BONE/JOINTS/MUSCLE			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ENDOCRINE			
(thyroid glands)	☐	☐	☐
PSYCHIATRIC	☐	☐	☐
INTEGUMENTARY			
(Skin)	☐	☐	☐
NEUROLOGIC			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐

EXPLANATION AND/OR CONDITIONS NOT NOTED ABOVE: ____

____

____

____

Social History

Please indicate hobbies and interests: ☐Computers ☐Hunting ☐Fishing ☐Music ☐Public Speaking ☐Golfing

Do you drive? ☐No ☐Yes

Do you use tobacco products? No ☐ Yes ☐ if yes, type/amount/how long: ______________________________

Do you use alcohol? No ☐ Yes ☐ if yes, type/amount/how long: ______________________________

Do you use illegal drugs? No ☐ Yes ☐ if yes, type/amount/how long: ______________________________

Please indicate if you have been exposed to or infected with: ☐Gonorrhea ☐Syphilis ☐HIV ☐Hepatitis

FOR DOCTOR'S USE:

Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM
Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM
Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM
Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM
Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM	Reviewed: ___/___/___ GM MM CM