



WELCOME TO EYEDENTITY

Patient Name _____

Date of Birth: ____ / ____ / ____ SS# ____ / ____ / ____ Sex: M F

Address: _____ City _____ State _____ Zip _____

Home Ph# _____ Work Ph# _____ Cell# _____

Can we notify you by email for appointments? Yes No Email Address _____

Can we text notify you for appointments? Yes No Cell# _____

Employer: _____ Occupation: _____

Are you a full time student?: Yes No

Marital Status: Single Married Divorced Widowed

Responsible Party Name: _____ D.O.B. ____ / ____ / ____

Relationship to Patient: _____ SS# ____ - ____ - ____

Name of Vision Insurance: _____ ID# _____

Name of Health Insurance: _____

How did you hear about us? _____

Are you a Contact Lens Wearer? Yes No What type? _____

If no, are you interested in contact lens today? Yes No

How often do you replace your Contacts? _____ Enzyme? _____

What type of solution do you use? _____

What is your main complaint with your vision today?

Payment for services is due on the day of your visit. We file insurance for all plans for which we are a provider. If we are not a provider in some cases we can file your claim so that you may be reimbursed. You are liable for any co-payments, deductibles and any charges which may not be covered under your plan. A deposit is required for processing any material orders with the balance due on delivery.

Patient Sign: _____ Date ____ / ____ / ____

OR

Responsible Party Sign: _____ Date ____ / ____ / ____

Medical History:

Name: _____ Today's Date _____
Date of Birth: ____/____/____ SS# ____/____/____
Last Eye Doctor: _____ Last Eye Exam ____/____/____ (Mon & Yr)
Current Medical Doctor: _____ Last Medical Exam ____/____/____ (Mon & Yr)

Medical History:

Do you have any allergies to medications? Yes No

If yes, explain: _____

List any medications 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- _____

Check any of the following that you have had:

Check one Reading Difficulty Crossed Eyes Lazy Eye Glaucoma Retinal Disease Cataracts Eye Injury
Are you pregnant and/ or nursing? Yes No
Do you wear glasses? Yes No If yes, how old is you present pair of glasses? _____
How many pair of glasses do you currently use? _____
Do you wear contact lenses? Yes No If yes, how old is your present pair of contacts? _____
Type of contact lenses? Rigid Soft Extended Wear Other Are they comfortable? Yes No
Have you had refractive surgery? Yes No
At work: Do you perform fine or close-up work? Yes No Is safety protection a concern at work? Yes No
Are you outdoor all or part of the time? Yes No
Do you have trouble reading signs when driving at night? Yes No
Are you bothered by the glare from: Overhead lighting? Yes No
Oncoming headlights at night? Yes No
A computer screen? Yes No
Are you sensitive in bright sunlight? Yes No
What hobbies or recreational sports do you enjoy? _____

Family History:

Have any of your relatives, living or deceased, had any of these conditions? Relationship To You

Ocular Disease/Condition	Yes	No	Not Sure	_____
Blindness	Yes	No	Not Sure	_____
Cataract	Yes	No	Not Sure	_____
Crossed Eyes	Yes	No	Not Sure	_____
Glaucoma	Yes	No	Not Sure	_____
Macular Degeneration	Yes	No	Not Sure	_____
Retinal Detachment/ Disease	Yes	No	Not Sure	_____
Systemic Disease / Condition				
Arthritis	Yes	No	Not Sure	_____
Cancer	Yes	No	Not Sure	_____
Diabetes	Yes	No	Not Sure	_____
Heart Disease	Yes	No	Not Sure	_____
High Blood Pressure	Yes	No	Not Sure	_____
HIV/AIDS	Yes	No	Not Sure	_____
Lupus	Yes	No	Not Sure	_____
Thyroid Disease	Yes	No	Not Sure	_____
Other				_____

Social History:

Patient Name: _____ Date: _____

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor.

(Check box) Do you drive? Yes No

If yes, do you have visual difficulty when driving? Yes No If yes, please describe: _____

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use recreational drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis Syphilis No, I have not.

Review of Systems:

Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	Not Sure	System	Yes	No	Not Sure
Cancer	Yes	No	Not Sure	Ears, Nose, Mouth, Throat	Yes	No	Not Sure
Constitutional				Allergies/Hay Fever	Yes	No	Not Sure
Fever, Weight Loss/Gain	Yes	No	Not Sure	Sinus Congestion	Yes	No	Not Sure
Skin (Integumentary)	Yes	No	Not Sure	Runny Nose	Yes	No	Not Sure
Neurological				Post-Nasal Drip	Yes	No	Not Sure
Headaches	Yes	No	Not Sure	Chronic Cough	Yes	No	Not Sure
Migraines	Yes	No	Not Sure	Dry Throat/ Mouth	Yes	No	Not Sure
Seizures	Yes	No	Not Sure	Respiratory			
Eyes				Asthma	Yes	No	Not Sure
Loss of Vision	Yes	No	Not Sure	Chronic Bronchitis	Yes	No	Not Sure
Blurred Vision	Yes	No	Not Sure	Emphysema	Yes	No	Not Sure
Distorted Vision/Halos	Yes	No	Not Sure	Vascular/Cardiovascular			
Loss of Side Vision	Yes	No	Not Sure	Diabetes	Yes	No	Not Sure
Double Vision	Yes	No	Not Sure	Heart Pain	Yes	No	Not Sure
Dryness	Yes	No	Not Sure	High Blood Pressure	Yes	No	Not Sure
Mucous Discharge	Yes	No	Not Sure	Vascular Disease	Yes	No	Not Sure
Redness	Yes	No	Not Sure	Brain Injury/Stroke	Yes	No	Not Sure
Sandy or Gritty Feeling	Yes	No	Not Sure	Gastrointestinal			
Itching	Yes	No	Not Sure	Diarrhea	Yes	No	Not Sure
Burning	Yes	No	Not Sure	Constipation	Yes	No	Not Sure
Foreign Body Sensation	Yes	No	Not Sure	Genitourinary	Yes	No	Not Sure
Excess Tearing/ Watering	Yes	No	Not Sure	Genitals/Kidney/Bladder	Yes	No	Not Sure
Glare/Light Sensitivity	Yes	No	Not Sure	Bones/Joints/Muscles			
Eye Pain or Soreness	Yes	No	Not Sure	Rheumatoid Arthritis	Yes	No	Not Sure
Chronic Infection of Eye/ Lid	Yes	No	Not Sure	Muscle Pain	Yes	No	Not Sure
Sty of Chalazion	Yes	No	Not Sure	Joint Pain	Yes	No	Not Sure
Flashes/Floaters in Vision	Yes	No	Not Sure	Lymphatic/Hematologic			
Tired Eyes	Yes	No	Not Sure	Anemia	Yes	No	Not Sure
Endocrine	Yes	No	Not Sure	Bleeding Problems	Yes	No	Not Sure
Thyroid/Other Glands	Yes	No	Not Sure				
Psychiatric	Yes	No	Not Sure	Allergic/Immunologic	Yes	No	Not Sure

DO NOT WRITE BELOW THIS LINE (Doctor's Comments):

I have reviewed this history with the patient:

Doctor's Signature	Date