Welcome to Eye Care Associates

First Name:_____ MI_____Last Name:_____DOB _____
Address: _____ City:_____ State:_____Zip:_____
SS: _____Marital Status:_____Gender:_____ Employer/Occupation:_____
Cell:_____ Home:_____ Work:_____
PCP_____ Last Eye Exam/Dr.:_____

REASON FOR VISIT: Please check all that apply.

☐ Burning ☐ Itching ☐ Eye pain ☐ Glare/Light Sensitive ☐ Eye Turned in or Out ☐ Redness
☐ Tired Eyes ☐ Discharge ☐ Watering ☐ Droopy Eyelid ☐ Eye Injury
☐ Double Vision ☐ Blurred Distance ☐ Distorted Vision ☐ Fluctuating Vision ☐ Dry, Sandy, Gritty
Other:_____

Glasses/Contacts:

Do you wear glasses? _____ **Are you interested in new glasses today?** _____
Are you interested in contacts today? _____ **Have you worn contacts before?** _____
What brand and solutions do you use? _____
Comfort: ___Good ___Fair ___Poor **Vision:** ___Good ___Fair ___ Poor

Past/Current Medical History: Please check all that apply.

Constitutional: ☐ Developmental Disabilities ☐ Cancer ☐ Fatigue Syndrome
Ear, Nose, Mouth, & Throat: ☐ Hearing Loss ☐ Sinusitis ☐ Dry mouth ☐Laryngitis
Cardiovascular: ☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease ☐ Congestive Heart Failure
Respiratory: ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep Apnea ☐ COPD
Gastrointestinal: ☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease
Genitourinary: ☐ Kidney Disease ☐ Prostate Disease/Cancer ☐ STD ☐ Pregnant ☐
Musculoskeletal: ☐ Osteoarthritis ☐ Arthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Osteoporosis
Integumentary: ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Cold Sores ☐ Shingles
Neurological: ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Stroke ☐ Autism ☐ Migraine
Psychiatric: ☐ Depression ☐ Attention Deficit ☐ Anxiety ☐ Bipolar Disorder
Endocrine: ☐Thyroid Dysfunction ☐Hormonal Dysfunction ☐ Diabetes-Type___How long____A1C___
Hematological/ Lymphatic: ☐ Anemia ☐ Large-Volume Blood Loss ☐ High Cholesterol
Immunological: ☐ Rheumatoid Arthritis ☐ Lupus ☐ Sjogren's Syndrome
Eye History: ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Eye Surgery
No medical history: ☐ NONE
Other (If not listed above): _____
Allergies: _____
Medications: _____

Do you use tobacco?_____ **How often?**_____ **Do you use alcohol?**_____ **How often?**_____

Family Medical History: (Father, Mother, Brother, Sister, Son, Daughter) Please circle those diagnosed.

☐ Diabetes (F, M, B, Si, So, D) ☐ High Blood Pressure (F, M, B, Si, So, D) ☐ Thyroid Dysfunction (F, M, B, Si, So, D)
☐ Glaucoma (F, M, B, Si, So, D) ☐ Macular Degeneration (F, M, B, Si, So, D) ☐ Cataracts (F, M, B, Si, So, D)
☐ Cancer (F, M, B, Si, So, D)

Receipt of HIPAA Acknowledgement

I authorize the release of my medical information (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I acknowledge that I have received a copy of HIPAA Compliance, all fees are due at the time of service and that all information is correct to the best of my knowledge.

Signature of Patient or Guardian: _____ **Date:**_____