EYECARE ASSOCIATES

Patient Health History

Please note any health history below or check ☐ None:

Ocular (cataracts, glaucoma, macular degeneration, surgery, etc) _____

Constitutional (cancer, developmental disabilities, etc) _____

Ears, Nose, Throat (hearing loss, sinusitis, dry mouth, etc) _____

Neurological (MS, migraine, vertigo, cerebral palsy, stroke, etc) _____

Psychological (depression, bipolar, ADHD, anxiety, etc) _____

Cardiovascular (high blood pressure, heart disease, etc) _____

Respiratory (asthma, bronchitis, COPD, etc) _____

Gastrointestinal (acid reflux, Crohn's, Colitis, Celiac, etc) _____

Genitourinary (STD, kidney disease, etc) _____

Musculoskeletal (arthritis, Fibromyalgia, muscular dystrophy, etc) _____

Dermatological (eczema, psoriasis, rosacea, shingles, cold sores) _____

Endocrine (diabetes, thyroid, etc) _____

Diabetes Doctor (PCP or Endocrinologist) _____ Year Diagnosed _____

Last fasting blood sugar: _____ Last A1C _____

Hematological/Lymphatic (anemia, cholesterol, etc) _____

Allergy/Immunology (lupus, Sjogren's, etc) _____

Primary Care Physician:_____

Allergies: _____

Medications: _____

_____

Do you use tobacco? YES NO Do you drink alcohol? YES NO

Are you pregnant or nursing? YES NO

Family Medical History:

Cancer	Mother	Father	Brother	Sister
Diabetes	Mother	Father	Bother	Sister
Hypertension	Mother	Father	Brother	Sister
Thyroid	Mother	Father	Brother	Sister
Cataracts	Mother	Father	Brother	Sister
Glaucoma	Mother	Father	Brother	Sister
Macular Degen.	Mother	Father	Brother	Sister

EYECARE ASSOCIATES

Patient Information

First Name: _____ Address: _____

Last Name: _____ City: _____

Preferred Name: _____ State: _____

Title: _____ Zip: _____

Date of Birth: _____ Primary Phone: _____

SS#: _____ Cell or Home? (please circle)

Email: _____ Texting okay? ☐ YES ☐ NO

Insurance Information

Medical Insurance: _____ Vision Insurance: _____

Subscriber Name: _____ Subscriber SS#: _____

Subscriber Birthdate: _____ Member ID: _____

Do you wear glasses? ☐ YES ☐ NO

Are you interested in contact lenses? ☐ YES ☐ NO Have you worn contacts before? ☐ YES ☐ NO

Employer: _____ Occupation: _____

Do you use a computer or digital device for extended periods of time? ☐ YES ☐ NO

Do your eyes often feel dry, gritty, or irritated? ☐ YES ☐ NO

Do you drive? ☐ YES ☐ NO

Do you have any hobbies or activities that require specific visual needs? ☐ YES ☐ NO

If yes, please list: _____

Patient Signature_____Date_____

Guardian if for a minor_____

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