

Eyedentity

WELCOME TO EYEDENTITY

Patient Name: _____

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

Address: _____ City _____ State _____ Zip _____

Home Ph# _____ Work Ph# _____ 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: _____ SSN# ____-____-____

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 Signature: _____ Date ____/____/____

or

Responsible Party Signature: _____ Date ____/____/____

Medical History Questionnaire

Name: _____
 Birth Date: ___/___/___ Social Security#: ___/___/___
 Last Eye Doctor: _____
 Current Medical Doctor: _____

Today's Date: _____
 Last Eye Exam: ___/___/___
Mth Year
 Last Medical Exam: ___/___/___
Mth 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: _____

Check any of the following that you have had: 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?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/ Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Systemic Disease / Condition				
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History *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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constitutional				Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin (Integumentary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory			
Eyes				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye/ Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sty of Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

7B`ABG`J E<G8`58?BJ `G; <F`?<A 8 (Doctor's Comments):

I have reviewed this history with the patient: _____
Doctor's Signature/Date