



COMPLETE FAMILY EYECARE

## WELCOME TO OUR OFFICE

### Patient Information

Today's Date \_\_\_\_\_

Last \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Other / Cell Phone \_\_\_\_\_

Preferred Phone: Home / Cell / Other

Patient's Last 4 of SSN \_\_\_\_\_

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation (or Grade) \_\_\_\_\_

Gender:  M  F

Marital Status:  Single  Married  
 Widowed  Divorced

Preferred Language:  English  Spanish  
 Other \_\_\_\_\_

**Race:**  American Indian or Alaska Native  
 Asian  Black or African American  
 Native Hawaiian or Pacific Islander  White  
 Other \_\_\_\_\_

**Ethnicity:**  
 Hispanic or Latino  Not Hispanic or Latino

Employer (or School) \_\_\_\_\_

Spouse (or Parent's Name) \_\_\_\_\_

Spouse (or Parent's Work) \_\_\_\_\_

**What is the major purpose of this visit?**  
\_\_\_\_\_

**Any problems with your current contact lenses or glasses?** \_\_\_\_\_  
\_\_\_\_\_

### Insurance Information

*Please note that insurance does NOT typically cover the Contact Lens Fit and Follow-Up Evaluation.*

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Last 4 of SSN \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

### Lifestyle Questions

**Do you.....(check box if your answer is yes)**

- ..work at a computer? If yes, please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..spend time outdoors? How much? \_\_Hrs/week
- ..have prescription sunwear?
- ..want information on Laser Vision Correction surgery?
- ..have children?
- ..**have family members in need of eyecare?**

**Have you ever experienced, been diagnosed or treated for any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision             | <input type="checkbox"/> Eye Infections          |
| <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Itchiness               |
| <input type="checkbox"/> Crossed eye/Eye turn      | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Redness                   | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light            | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration      | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment        | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing/ Burning          | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Other eye disorders _____ |  |

Who may we thank for referring you to our office?

**Name of friend or relative:** \_\_\_\_\_

If not referred, how did you choose our office?

- Another Dr.  Insurance List
- Saw Sign/Building  Newspaper/Radio/TV
- Yellow Pages: Which Directory? \_\_\_\_\_
- Web Page: Which Web Site? \_\_\_\_\_
- Other \_\_\_\_\_

The information in this confidential case history form is critical to the evaluation of your vision and health.

**Patient Medical History**

Name of Family Physician \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

**CURRENT MEDICATIONS (Rx or Over the Counter)**  
(List name of medications including eye drops, vitamins, & birth control pills) \_\_\_\_\_

Allergies to medications?  Yes  No

If so, what medications? \_\_\_\_\_

Have you had any surgeries?  Yes  No

If yes, what surgeries? \_\_\_\_\_

Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Weight: \_\_\_\_\_ lbs.

Have you ever been diagnosed or treated for the following health problems?

	Currently	In Past	Never
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last blood work: _____ HbA1C: _____			
Digestive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you/ have you ever use(d) cigarettes?  Yes  No  
 If yes, packs per day? \_\_\_\_\_  
 Do you drink alcohol?  Yes  No  
 If yes, how many drinks per week? \_\_\_\_\_  
 Do you take illegal drugs?  Yes  No

**Patient Eye History**

Date of Last Eye Exam \_\_\_\_\_  
 By Whom? \_\_\_\_\_  
 Have you ever tried contact lenses?  Yes  No  
 Do you currently wear contact lenses?  Yes  No  
 What kind? \_\_\_\_\_  
 Solutions used \_\_\_\_\_  
 Are you satisfied with the vision and comfort of your contact lenses?  Yes  No  
**Are you interested in learning more about LASIK and other vision correction surgery?**  Yes  No

**Family Medical/Eye History (Check all that apply)**

Is there a family medical history of any of the following:  
 No  Yes (Please check boxes)  
**Relationship (Mother's or Father's side)**  
 Glaucoma  \_\_\_\_\_  
 Cataracts  \_\_\_\_\_  
 Corneal Problems  \_\_\_\_\_  
 Macular Degeneration  \_\_\_\_\_  
 Blindness  \_\_\_\_\_  
 Retinal Problems  \_\_\_\_\_  
 Lazy Eye  \_\_\_\_\_  
 Diabetes  \_\_\_\_\_  
 Heart Disease  \_\_\_\_\_  
 High Blood Pressure  \_\_\_\_\_

**Our mission at Complete Family Eyecare is to contribute to a lifetime of healthy vision for all of our patients. Through the care we provide, we are committed to the visual needs, wellness, and improved quality of life for our patients. Continuing education will remain at the forefront of our priorities to ensure we offer the latest eye care, technology and products. Our staff is dedicated to providing you with the highest level of care as we grow together.**