EYECARE *of Great Bend*

LARNED *Eye Health*

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PATIENT PERSONAL INFORMATION

DATE: _____

Name _____
Address _____
City _____ St. _____ Zip _____
Home # _____ Work # _____
Cell # _____ SS# _____
E-mail _____
School (Grade) _____
Occupation (Employer) _____
D.O.B. _____ Age _____ Sex: M ____ F ____
Emergency Contact: _____
Spouse/Parent Name _____
Spouse/Parent Work # _____

Insurance Card Holder Information:
Name _____
Address _____
City _____ St. _____ Zip _____
Home # _____ Work # _____
Cell # _____ Employer: _____
SS# _____ D.O.B. _____

How will you settle your account today?

- Vision Insurance _____
- Check/Cash
- Credit Card

Person responsible for billing if not same as above?
Name _____
Address _____
City _____ St. _____ Zip _____
Home # _____ Work # _____ Cell # _____
SS# _____ D.O.B. _____

What's the purpose of this visit? _____
_____
Any problems now with glasses or contacts? _____
_____

Were you referred to us?
If yes, who can we reward? _____

DO YOU EXPERIENCE...

___ Burning	___ Loss of vision
___ Itching	___ Sensitive to light
___ Nausea	___ Faint/Dizziness
___ Watery eyes	___ Flashes of light
___ Tearing	___ Blurry near vision
___ Dryness	___ Blurry distant vision
___ Floating Objects	___ Gritty feeling
___ Glare/Reflection	___ Trouble at night
___ Seeing spots	___ Reading problems
___ Soreness	___ Trouble w/ glasses
___ Headaches	___ Trouble w/ contacts
___ Redness	___ Other
___ Double vision	

DO YOU: Y=YES N= NO

Work on a computer majority of the time? _____

Wear Bifocals/Trifocals? _____
If so, are you bothered by head tilting, restricted area of vision, poor focus, etc? _____

Always wear glasses? _____

Spend a lot of time outdoors? _____

Have you ever worn/are wearing contacts? _____
If yes, what kind? _____
Solution used? _____

If no, are you interested in contact lenses? _____

PLEASE COMPLETE REVERSE SIDE....

Patient: _____ Date of Last Eye Exam: _____

Emergency Contact: Emergency Contact Telephone #:

◆ (ROHS) REVIEW OF HEALTH SYSTEM

◆ EYES Have you had or do you have any of the following?

Glaucoma:	☐ Yes ☐ No	Explain:
Cataracts:	☐ Yes ☐ No	Explain:
Dry Eyes:	☐ Yes ☐ No	Explain:
Other eye problems:	☐ Yes ☐ No	Explain:

Please describe any problems with the following health systems:

◆ CONSTITUTIONAL ☐No Problem
☐Developmental Disability ☐Cancer ☐Fatigue Syndrome
☐Other:

◆ GASTROINTESTINAL (GI) ☐No Problem
☐Chrohn's ☐Colitis ☐Ulcer ☐Acid Reflux
☐Celiac Disease
☐Other:

◆ EARS/NOSE/THROAT ☐No Problem
☐Hearing Loss ☐Sinusitis ☐Dry Mouth ☐Laryngitis
☐Other:

◆ GENITURINARY (GU) ☐No Problem
☐Kidney Disease ☐Prostate Disease / Cancer ☐STD
☐Benign Prostate Hypertrophy ☐Pregnant ☐Nursing
☐Herpes ☐Chlamydia
☐Other:

◆ NEUROLOGICAL ☐No Problem
☐Multiple Sclerosis ☐Epilepsy ☐Cerebral Palsy ☐Tumor
☐Stroke ☐Migraine ☐Autism Spectrum Disorder
☐Other:

◆ MUSCULOSKELETAL ☐No Problem
☐Arthritis ☐Osteoarthritis ☐Fibromyalgia
☐Muscular Dystrophy ☐Ankylosing Spondylitis
☐Osteoporosis ☐Gout
☐Other:

◆ PSYCHIATRIC (MENTAL) ☐No Problem
☐Depression ☐Attention Deficit ☐Anxiety Disorder
☐Bipolar Disorder
☐Other:

◆ INTEGUMENTARY (SKIN) ☐No Problem
☐Eczema ☐Rosacea ☐Psoriasis
☐Herpes Simplex / Cold Sores ☐Herpes Zoster / Shingles
☐Other:

◆ CARDIOVASCULAR ☐No Problem
☐Hypertension ☐Stroke/ CVA ☐Heart Disease
☐Vascular Disease ☐ Congestive Heart Failure
☐Other:

◆ ENDOCRINE (GLAND) ☐No Problem
☐Type 1 Diabetes ☐Type 2 Diabetes ☐Thyroid Dysfunction
☐Hormonal Dysfunction
☐Other:

◆ RESPIRATORY ☐No Problem
☐Asthma ☐Bronchitis ☐Emphysema
☐Chronic Obstruction ☐Sleep Apnea
☐Other:

◆ HEMOTOLOGIC/LYMPHATIC (BLOOD) ☐No Problem
☐Anemia ☐Large Volume Blood Loss ☐Ulcer
☐Hypercholesteremic
☐Other:

◆ ALLERGIC/IMMUNE ☐No Problem
☐Drug Allergies ☐Environmental Allergies
☐Rheumatoid Arthritis ☐Lupus
☐Sjogren's Syndrome ☐Latex Sensitivity
☐Other:

◆ ALL MEDICATIONS CURRENTLY TAKING

◆ ALL MEDICATION ALLERGIES

★ (ROHS) REVIEW OF HEALTH SYSTEM

★ PATIENT HISTORY

Have you had any eye operations? ☐ Yes ☐ No Date: _____ Type: _____
Have you had an eye injury? ☐ Yes ☐ No Date: _____ Type: _____
Have you had a retinal detachment? ☐ Yes ☐ No Date: _____ Treatment: _____
Name of family doctor: _____
List any eye medications you are currently taking:

★ SOCIAL HISTORY

Do you use alcohol? ☐ Yes ☐ No Amount: _____
Do you use tobacco? ☐ Yes ☐ No Amount: _____
Do you use other substances? ☐ Yes ☐ No What: _____
Describe any special visual needs:

★ FAMILY HISTORY

Cancer ☐ Yes ☐ No Relation _____
Diabetes ☐ Yes ☐ No Relation _____
Hypertension ☐ Yes ☐ No Relation _____
Hyperthyroidism ☐ Yes ☐ No Relation _____
Other eye Condition ☐ Yes ☐ No Relation _____

Cataracts ☐ Yes ☐ No Relation _____
Macular Degeneration ☐ Yes ☐ No Relation _____
Glaucoma ☐ Yes ☐ No Relation _____
Retinal Detachment ☐ Yes ☐ No Relation _____
Description: _____