# WELCOME TO OUR OFFICE!

**Today's Date:**

## Patient Information

Last ______________________________

First ____________________MI ______________

Date of Birth ____________________Age ________

Sex   M   F

Street ______________________________

City _______________ State ________________

Zip Code ______________________________

Home Phone ______________________________

Work Phone ______________________________

Cell Phone ______________________________

SSN ______________________________

Email ______________________________

Text opt in (circle): Yes   No   Email opt in: Yes   No

Employer ______________________________

Occupation ______________________________

Spouse ______________________________

Emergency Contact (Name & Phone #):

______________________________

### *NEW PATIENTS ONLY:*

Who may we thank for referring you to our office?

______________________________

If not referred, how did you choose our office?

- ❑ Referred from another Dr:_______________
- ❑ Insurance List
- ❑ Sign/Building
- ❑ Social Media (Facebook, Instagram, LinkedIn)
- ❑ Website
- ❑ Other ______________________________

## Patient Eye History

Date of Last Eye Exam__________________________

Doctor or Clinic:______________________________

Do you currently wear glasses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

If not, are you interested in contact lenses? ❑ Yes ❑ No

## Patient Eye History

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

- ❑ Blurry Vision
- ❑ Burning
- ❑ Cataracts
- ❑ Corneal Abrasions
- ❑ Crossed eye/Eye turn
- ❑ Double Vision
- ❑ Eye Infections
- ❑ Eye Injury
- ❑ Flash of light
- ❑ Floaters/Spots
- ❑ Glaucoma
- ❑ Grittiness
- ❑ Headaches
- ❑ Iritis/Uveitis
- ❑ Itchiness
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Occasional dryness
- ❑ Retinal Detachment
- ❑ Sunlight Sensitivity
- ❑ Tearing
- ❑ Trouble seeing at night
- ❑ Uncomfortable glasses
- ❑ Keratoconus
- ❑ Corneal disorder
- ❑ Corneal dystrophy
- ❑ Other eye conditions:______________________

**Eye Surgeries**

- ❑ Lasik
- ❑ RK
- ❑ PRK
- ❑ SMILE
- ❑ Corneal transplant
- ❑ Other_______________

How many hours are you on the computer and/or electronic devices? ______________________

Do you experience eyestrain/fatigue/tiredness while using electronic devices? ❑ Yes ❑ No

## Patient Medical History

**CURRENT MEDICATIONS (Rx or Over the Counter)**
(List name of medications including eye drops, vitamins, & birth control pills) ❑ None

______________________________

______________________________

______________________________

Allergies to medications? ❑ Yes ❑ No
If so, what medications?______________________

Have you had any surgeries? ❑ Yes ❑ No
If so, what surgeries? ______________________

Do you use cigarettes/tobacco? ❑ Yes ❑ No
(Circle): Everyday Occasionally

Do you use other substances? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No
(Circle): Everyday Occasionally

## Patient Medical History

**Are you currently experiencing any of the following?**

| **General** | **Yes** | **No** |
|---|---|---|
| Fatigue | ❑ | ❑ |
| Fever | ❑ | ❑ |
| Unusual weight gain/loss | ❑ | ❑ |
| Cancer | ❑ | ❑ |
| Gastrointestinal problems | ❑ | ❑ |
| **Ear, nose, throat** | | |
| Cough | ❑ | ❑ |
| Runny nose | ❑ | ❑ |
| Sinus | ❑ | ❑ |
| Throat soreness | ❑ | ❑ |
| **Cardiovascular** | | |
| High blood pressure | ❑ | ❑ |
| Heart disease | ❑ | ❑ |
| High cholesterol | ❑ | ❑ |
| Vascular disease | ❑ | ❑ |
| Sleep apnea | ❑ | ❑ |
| **Respiratory** | | |
| Asthma | ❑ | ❑ |
| Bronchitis | ❑ | ❑ |
| COPD | ❑ | ❑ |
| **Genitourinary** | | |
| Kidney problems | ❑ | ❑ |
| Prostate problems | ❑ | ❑ |
| **Musculoskeletal** | | |
| Arthritis | ❑ | ❑ |
| Joint pain | ❑ | ❑ |
| **Skin** | | |
| Eczema | ❑ | ❑ |
| Itching | ❑ | ❑ |
| Rosacea | ❑ | ❑ |
| **Neurological** | | |
| Headaches | ❑ | ❑ |
| Migraines | ❑ | ❑ |
| Multiple sclerosis | ❑ | ❑ |
| Seizures | ❑ | ❑ |
| **Psychiatric** | | |
| ADHD | ❑ | ❑ |
| Anxiety | ❑ | ❑ |
| Depression | ❑ | ❑ |
| **Endocrine** | | |
| Type 1 Diabetes | ❑ | ❑ |
| Type 2 Diabetes | ❑ | ❑ |
| Hyperthyroid | ❑ | ❑ |
| Hypothyroid | ❑ | ❑ |
| **Blood/lymph** | | |
| Anemia | ❑ | ❑ |
| Bleeding disorders | ❑ | ❑ |
| Leukemia | ❑ | ❑ |
| HIV | ❑ | ❑ |
| **Allergic/immunology** | | |
| Allergies | ❑ | ❑ |
| Throat Infections | ❑ | ❑ |
| Thyroid | ❑ | ❑ |
| **Other** | | |
| Pregnant/nursing | ❑ | ❑ |

## Family Medical/Eye History

Is there a family medical history of any of the following:

❑ No ❑ Yes (Please check boxes)

| | Relationship (e.g. mother, father, grandparent, sibling) |
|---|---|
| Eye Conditions | |
| Glaucoma | ❑ ______________________ |
| Cataracts | ❑ ______________________ |
| Macular Degeneration | ❑ ______________________ |
| Retinal Problems | ❑ ______________________ |
| Strabismus (lazy eye) | ❑ ______________________ |
| Blindness | ❑ ______________________ |
| Keratoconus | ❑ ______________________ |
| Corneal transplant | ❑ ______________________ |
| Medical Conditions | |
| Diabetes | ❑ ______________________ |
| Hypertension | ❑ ______________________ |
| High Cholesterol | ❑ ______________________ |
| Thyroid | ❑ ______________________ |
| Cardiovascular | ❑ ______________________ |
| Other | ❑ ______________________ |

*Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Contemporary Eye Care.*

*If your insurance company has not reimbursed our office in full within 90 days, you may be responsible for providing payment in full to Contemporary Eye Care.*