Advanced Eyecare & The Eyewear Gallery

❑Last _____❑_____ First _____ Date of Birth _____Age _____Sex _____

Street Address
_____
City _____ State _____ Zip
_____

Email Address
_____
Home Phone _____
Day Phone

Race _____ Ethnicity
_____
Preferred Language
_____

Employer
_____
Occupation

Name of Spouse or Parent/Guardian _____ Spouse/Guardian Employer

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Social Security # _____

Vision Insurance
_____
Subscriber Name _____
Subscriber ID # _____
Subscriber Birth Date _____

Primary Medical Insurance
_____
Subscriber Name _____
Subscriber ID # _____
Subscriber Birth Date _____

Alternate Medical Insurance
_____
Subscriber Name _____
Subscriber ID # _____
Subscriber Birth Date

GENERAL PATIENT HISTORY

Date of Last Eye Exam
_____
By Whom?
_____

Primary Care Provider
_____
City
_____
_
Date of Last Physical Exam
_____

Have you ever tried contact lenses?
_____
Do you currently wear contact lenses?
_____
If yes, what kind?

Please describe your current vision/eye complaints _____

❑ Blurry vision ❑ Sunlight Sensitivity ❑ Burning ❑ Floater/spots ❑ Crossed eye/eye turn ❑ Tearing
❑ Grittiness ❑ Trouble seeing at night ❑ Headaches ❑ Itchiness ❑ Uncomfortable glasses ❑ Flash of light
❑ Double vision ❑ Occasional dryness ❑ Other eye disorders

Are you pregnant? _____
Do you use tobacco or tobacco products? _____ If yes, how often? _____
Have you used tobacco or tobacco products in the past? _____ If yes, how long ago did you quit? _____
Do you consume alcoholic beverages? _____ If yes, how often? _____

Please list any systemic (non-eye) surgeries and their dates: -
_____
Please list any eye surgeries and their dates:
_____

CURRENT MEDICATIONS (Rx and over the counter, including eye drops, vitamins, and birth control pills)

_____ _____
_____
_____ _____
_____
_____ _____
_____

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Do you or members of your family have a medical history of any of the following?

								Paternal		Maternal	
	Self	**Mother**	**Father**	**Sister**	**Brother**	**Aunt**	**Uncle**	**Grandmother**	**Grandfather**	**Grandmother**	**Grandfather**
Blindness											
Cataracts											
Corneal Problems											
Glaucoma											
Lazy Eye											
Macular Degeneration											
Retinal Problems											
Allergies											
Anxiety											
Arthritis											
Asthma											
Depression											
Diabetes											
Heart Disease											
Cancer											
Indicate Type:											
High Blood Pressure											
High Cholesterol											
Kidney Disease											
Thyroid											
Other:											

Thank you! We look forward to having you in our office!