Advanced Eyecare & The Eyewear Gallery

Last _____ First _____ Date of Birth _____Age _____Sex _____

Street Address _____ Race _____ Ethnicity _____
City _____ State _____ Zip _____ Preferred Language _____

Email Address _____ Employer _____
Home Phone _____ Occupation _____
Day Phone _____
Cell Phone _____ Referred By _____
Preferred Method of Contact: Text Email Phone

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

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 _____
Do you participate in an FSA or HSA? _____

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? _____

Do you… (check all that apply)
- ❑ work at a computer?
- ❑ spend time outdoors?
- ❑ have prescription sunglasses?
- ❑ want information on Laser Vision Correction surgery?

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)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication Allergies ❑ No ❑ Yes, please list:

_____

Allergies (non-medication): _____

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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!