Family Eye Center

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Today's Date _____ Email Address_____

Last Name_____**First Name**_____MI _____
Address_____City_____State_____Zip _____
Primary Phone #_____ Secondary Phone #_____
Date of Birth_____Occupation_____Employer _____
Emergency Contact Name_____Phone Number_____
Date of Last Eye Exam_____Dilated? Yes/No Referred By_____
Primary Vision Coverage_____ID Number _____
Medical Insurance Coverage _____ID Number_____
Social Security Number: _____-_____-_____ Do you Smoke? Yes/No If Yes how much?_____
Do you Drink? Yes/No If yes how many drinks per week?_____
Ethnicity:_____ Decline to answer or specify:_____
Hispanic or Latino:_____ Native Hawaiian/other Pacific Island:_____ Not Hispanic or Latino:_____

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Cholesterol Hi/Lo	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No_____Type_____Date of diagnosis _____
Allergies to medication Yes/No Which?_____Reactions? _____
Other health problems _____
Current medication(s)_____
Have you had any operations? Yes/No Kind?_____When? _____
Name of family doctor and/or primary care physician _____
Date of last visit_____Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation_____		Macular degeneration	Yes/No	Relation_____	
Diabetes	Yes/No	Relation _____		Retinal detachment	Yes/No	Relation_____	
Glaucoma	Yes/No	Relation _____		Cataracts	Yes/No	Relation_____	

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type _____ Date_____
Have you had an eye injury? Yes/No Kind_____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type_____	

Additional information ___