COMPLETE FAMILY EYECARE

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Street _____

City _____

State _____ Zip Code _____

Home Phone _____

Other / Cell Phone _____

Preferred Phone: Home / Cell / Other

Patient's Last 4 of SSN _____

Email Address _____

Date of Birth _____ Age _____

Occupation (or Grade) _____

Gender: ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Preferred Language: ❑ English ❑ Spanish ❑ Other _____

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Other _____

Ethnicity:

❑ Hispanic or Latino ❑ Not Hispanic or Latino

Employer (or School) _____

Spouse (or Parent's Name) _____

Spouse (or Parent's Work) _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses? _____

_____

Insurance Information

Please note that insurance does NOT typically cover the Contact Lens Fit and Follow-Up Evaluation.

Primary Medical Insurance _____
Subscriber Name _____
Subscriber Last 4 of SSN _____
Subscriber Birth Date _____

Lifestyle Questions

Do you……(check box if your answer is yes)

❑..work at a computer? If yes, please complete computer questionnaire.
❑..think you might benefit from thinner, lighter lenses?
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..want information on Laser Vision Correction surgery?
❑..have children?
❑**..have family members in need of eyecare?**

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

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Redness
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing/ Burning
❑ Eye Infections
❑ Itchiness
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other eye disorders _____

_____

Who may we thank for referring you to our office?

Name of friend or relative: _____

If not referred, how did you choose our office?

❑ Another Dr. ❑ Insurance List
❑ Saw Sign/Building ❑ Newspaper/Radio/TV
❑ Yellow Pages: Which Directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____

Phone Number: _____

Date of Last Visit:_____

Preferred Pharmacy: _____

Pharmacy Phone Number:_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

_____

_____

Allergies to medications? ❑ Yes ❑ No

If so, what medications?_____

_____

Have you had any surgeries? ❑ Yes ❑ No

If yes, what surgeries? _____

_____

Height: _____ ft _____ in
Weight: _____ lbs.

Have you ever been diagnosed or treated for the following health problems?

	Currently	In Past	Never
Allergies	❑	❑	❑
Arthritis	❑	❑	❑
Blood/Lymph	❑	❑	❑
Bronchitis	❑	❑	❑
Cancer	❑	❑	❑
Cholesterol	❑	❑	❑
Diabetes	❑	❑	❑
Date of last blood work: _____ HbA1C: _____			
Digestive	❑	❑	❑
Ears/Nose/Throat	❑	❑	❑
Endocrine	❑	❑	❑
Fatigue	❑	❑	❑
Chronic Fevers	❑	❑	❑
Genitourinary	❑	❑	❑
High Blood Pressure	❑	❑	❑
Integumentary (Skin)	❑	❑	❑
Kidney	❑	❑	❑
Muscle/Bone	❑	❑	❑
Neurological	❑	❑	❑
Psychological	❑	❑	❑
Respiratory	❑	❑	❑
Sinus	❑	❑	❑
Thyroid	❑	❑	❑
Unusual weight losses/gains	❑	❑	❑

Do you/ have you ever use(d) cigarettes? ❑ Yes ❑ No
If yes, packs per day? _____
Do you drink alcohol? ❑ Yes ❑ No
If yes, how many drinks per week? _____
Do you take illegal drugs? ❑ Yes ❑ No

Patient Eye History

Date of Last Eye Exam _____

By Whom? _____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind?_____

Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Are you interested in learning more about LASIK and other vision correction surgery? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

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

❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Glaucoma	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Macular Degeneration	❑_____
Blindness	❑_____
Retinal Problems	❑_____
Lazy Eye	❑_____
Diabetes	❑_____
Heart Disease	❑_____
High Blood Pressure	❑_____

Our mission at Complete Family Eyecare is to contribute to a lifetime of healthy vision for all of our patients. Through the care we provide, we are committed to the visual needs, wellness, and improved quality of life for our patients. Continuing education will remain at the forefront of our priorities to ensure we offer the latest eye care, technology and products. Our staff is dedicated to providing you with the highest level of care as we grow together.