EYE LIFE
VISION CENTER

Full Name _____ Date of Birth _____ Gender: M F

Email Address _____ Last 4 Digits of Social Security Number _____

Home Phone _____ Work Phone _____ Cell Phone _____ Parent if under 18 years old _____

Address _____ City, State, Zip Code _____

Last Eye Exam _____ Reason for Visit _____

Last Annual Physical _____ Name of Medical Doctor _____

How did you hear about us? ☐Family/Friends, ☐Insurance, ☐Drive-By, ☐Internet search, ☐Other: _____

Eye Health Information

Have you ever been diagnosed with any of the following conditions?

No Problems	☐	Age-Related Macular Degeneration	☐
Cataract	☐	Diabetes	☐
Glaucoma	☐	Dry Eye	☐
Diabetic Retinopathy	☐	Floaters and/or flashes of light	☐
Eye infection, inflammation, or allergy	☐	Retina defects or generations	☐
Iritis or Uveitis	☐	Other: _____	

Are you having any of the following eye concerns?

No Problems	☐	Burning	☐
Redness	☐	Tearing	☐
Itching	☐	Other: _____	
Discharge	☐		

Are you having any of the following vision concerns?

No Problems	☐	Poor night vision	☐
Blurred Vision	☐	Bothersome night glare	☐
Eye Strain	☐	Double vision	☐
Eye Pain	☐	Total loss of vision	☐
Sensitivity to lights	☐	Other: _____	
Headache	☐		

Medical Health History

List **all** medications you are currently taking (include non-prescription ie. vitamins/supplements): _____

_____

List any seasonal and/or medication allergies: _____

Do you have an allergy to latex? Yes ☐ No ☐

Are you currently pregnant or breastfeeding? Yes ☐ No ☐

Review of Systems

Do you currently, or have you ever had any problems in the following areas?

Constitutional:
No Problems ☐
Fatigue Syndrome ☐
Developmental Disabilities ☐
Cancer ☐
Other ☐

ENT:
No Problems ☐
Hearing Loss ☐
Sinusitis ☐
Dry Mouth ☐
Other ☐

Neurological:
No Problems ☐
Multiple Sclerosis ☐
Epilepsy ☐
Cerebral Palsy ☐
Tumor ☐
Stoke/CVA ☐
Migraine ☐
Autism Spectrum Disorder ☐
Other ☐

Psychiatric:
No Problems ☐
Depression ☐
Attention Deficit ☐
Anxiety Disorder ☐
Bipolar Disorder ☐
Other ☐

Cardiovascular:
No Problems ☐
Hypertension ☐
Stroke/CVA ☐
Heart Disease ☐
Vascular Disease ☐
Heart failure ☐
Other ☐

Respiratory:
No Problems ☐
Cigarette Smoker ☐
Asthma ☐
Bronchitis ☐
Emphysema ☐
Chronic Obstruction ☐
Other ☐

Gastrointestinal:
No Problems ☐
Crohn's ☐
Colitis ☐
Ulcer ☐
Acid Reflux ☐
Celiac Disease ☐
Other ☐

Genitourinary:
No Problems ☐
Kidney Disease ☐
Prostate disease/cancer ☐
STD-herpetic/chlamydia ☐
Benign Prostate Hyper. ☐
Herpes ☐
Other ☐

Musculoskeletal:
No Problems ☐
Arthritis ☐
Osteoarthritis ☐
Fibromyalgia ☐
Muscular Dystrophy ☐
Ankylosing Spondylitis ☐
Osteoporosis ☐
Gout ☐
Other ☐

Integumentary (Skin):
No Problems ☐
Eczema ☐
Rosacea ☐
Psoriasis ☐
Herpes Simplex/Cold Sores ☐
Herpes Zoster/Shingles ☐
Other ☐

Endocrine:
No Problems ☐
Type 2 Diabetes Mellitus ☐
Type 1 Diabetes Mellitus ☐
Thyroid Dysfunction ☐
Hormonal Dysfunction ☐
Other ☐

Hematologic/Lymphatic:
No Problems ☐
Anemia ☐
Large-volume blood loss ☐
Ulcer ☐
Hypercholesteremia ☐
Other ☐

Allergic/Immune:
No Problems ☐
Drug Allergies ☐
Environmental Allergies ☐
Rheumatoid Arthritis ☐
Lupus ☐
Sjogren's Syndrome ☐
Other ☐

Other: ☐

_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly to the doctor if you prefer.

Drinking: Yes ☐ No ☐ Tobacco Use: Yes ☐ No ☐

Amount: _____ Amount: _____

Smoking Status:

Current everyday smoker	☐	Current some day smoker	☐	Former smoker	☐
Heavy tobacco smoker	☐	Light tobacco smoker	☐	Never smoked	☐

Past Ocular History

Do you have any history in any of the following?

None / No problems	☐	Glaucoma Suspect	☐
Glaucoma	☐	Cataract	☐
Age Related Macular Degeneration	☐	Surgery	☐
Patching	☐	Inflammatory Disorder	☐
Strabismus	☐	Amblyopia	☐
Retinal degeneration	☐	Retinal Hole	☐
Retinal Detachment	☐	Keratoconus	☐
Injury	☐	Dry Eye	☐
Nystagmus	☐	Other	☐

Family Medical History

Do you have any immediate family (parents, siblings, children) history in any of the following?

	YES	NO	UNKNOWN	If "YES" Please Check Off Member
Cancer	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐
Diabetes(1 or 2)	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐
Hypertension	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐
Hyperthyroid	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐
Hypothyroid	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐

Family Ocular History

Do you have any immediate family (parents, siblings, children) ocular history in any of the following?

	YES	NO	UNKNOWN	If "YES" Please Check Off Member
Cataract	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐
Macular Degeneration	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐
Glaucoma	☐	☐	☐	Relationship: Father ☐ Mother ☐ Brother ☐ Sister ☐ Son ☐ Daughter ☐

By signing below, you acknowledge that the above information is accurate and complete. The patient/guardian accepts financial responsibility for any unpaid balances for services rendered. Please note insurance regulations mandate that we charge for all office visits that require you to see the physician. They also mandate that co-pays/payments are paid at the time of the service. All patients must be aware of their insurance benefits and coverage at the time of service. All patients must be aware of their insurance benefits and coverage at the time of their scheduled appointment and inform us accordingly. You are responsible for all charges not covered by your insurance. All insurance cards must be given for exams, glasses, or contacts. We cannot back date authorizations for exams, eyeglasses or contacts. Once you've purchased glasses/contacts we cannot submit to your insurance unless were made aware of your insurance prior to placing the order. You can, of course, submit your receipt to your insurance company for reimbursement.

Patient/Guardian's Signature _____ Date _____