

WELCOME TO DESERT FAMILY EYE CARE

Patient Information

Please Fill Out BOTH Sides *Side #1*

Name: _____	Today's Date: ____/____/____
Name you go by (if different) _____	Date of Birth: ____/____/____ Sex: M F
Home Address: _____	Social Security Number _____
City: _____ State _____ Zip _____	Driver's License Number _____
Home Phone: (____) _____ Work Phone: (____) _____	Occupation (or Grade) _____
Cell Phone: (____) _____	Employer (or School) _____
E-mail Address: _____	Who is responsible for paying your account? ____ Yourself ____ Other: Name & Relationship: _____
Other family members treated by our office: _____	
Whom may we thank for referring you to our office? _____	

Insurance Information

Do you have Vision Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please check below:	Subscribers Name _____
Vision Service Plan(VSP) <input type="checkbox"/> Medical Eye Services(MES) <input type="checkbox"/> EyeMed <input type="checkbox"/>	Subscribers SS# _____
Other Vision Insurance: _____	
Do you have Medical Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Insurance: _____	
Insurance ID Number _____	Name of Primary Care Physician: _____
Is it an <input type="checkbox"/> HMO(Health Maintenance Organization, eg Kaiser, Health Net) <input type="checkbox"/> PPO(Preferred Provider Organization, eg Blue Cross)	

Personal Visual History

What is the major purpose of your visit today? _____
When was your last comprehensive vision examination? <input type="checkbox"/> Never <input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4+ years
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you wear them <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Seldom How old are glasses? _____
For what purpose were they prescribed? <input type="checkbox"/> General use <input type="checkbox"/> Distance only <input type="checkbox"/> Near only <input type="checkbox"/> Computer <input type="checkbox"/> Safety <input type="checkbox"/> Other: _____
Chief Complaint(s): <input type="checkbox"/> None <input type="checkbox"/> Distance blur <input type="checkbox"/> Near blur <input type="checkbox"/> Intermediate blur <input type="checkbox"/> Computer blur & fatigue
<input type="checkbox"/> Trouble reading <input type="checkbox"/> Headaches <input type="checkbox"/> Eyestrain <input type="checkbox"/> Eyes burn <input type="checkbox"/> Eyes water <input type="checkbox"/> Pressure around eyes
<input type="checkbox"/> Gritty & sandy <input type="checkbox"/> Eye pain <input type="checkbox"/> Eyes red <input type="checkbox"/> Floaters <input type="checkbox"/> Flashes <input type="checkbox"/> Double vision
<input type="checkbox"/> Light sensitivity <input type="checkbox"/> Eyes itch <input type="checkbox"/> Decreased side vision <input type="checkbox"/> Other: _____
Eye surgeries: <input type="checkbox"/> None <input type="checkbox"/> Lasik <input type="checkbox"/> PRK <input type="checkbox"/> RK <input type="checkbox"/> Cataract <input type="checkbox"/> Retinal <input type="checkbox"/> Eyelid <input type="checkbox"/> Muscle-Other: _____
Have you had a serious eye injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____
Any other eye problems? _____

Contact Lens History

Are you interested in Contact Lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which statement applies to you? <input type="checkbox"/> I've never worn contact lenses (skip the rest of this section) <input type="checkbox"/> I wear contacts daily
<input type="checkbox"/> I wear contacts occasionally <input type="checkbox"/> I used to wear contacts
If you wear contacts, do you sleep in them? Regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No Occasionally <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how many nights in a row will you wear them without removal? _____
Are your contacts <input type="checkbox"/> Soft <input type="checkbox"/> Rigid <input type="checkbox"/> Disposable <input type="checkbox"/> Non-disposable <input type="checkbox"/> Monovision <input type="checkbox"/> Bifocal <input type="checkbox"/> For Astigmatism <input type="checkbox"/> Other
If soft disposable, which brand and lens power are you wearing (if known)? Brand _____ Power: Right _____ Left _____
How old is the pair you are currently wearing? _____
How frequently do you replace a pair? _____

Please Turn This Form Over and Complete Side #2

Personal Medical History

Do you take any prescription or non-prescription medicines regularly? Y N If yes, please list below or provide as attachment

Medication allergies: None Penicillin Sulfa Codeine Other:

Do you have any conditions of the following medical systems?	Please circle		If yes, please explain
Ear / Nose / Throat (e.g. soreness, hearing loss)	Y	N	_____
General constitution (e.g. fever, weight gain/loss, malaise)	Y	N	_____
Blood (e.g. anemia, bleeding disorders)	Y	N	_____
Genitourinary (e.g. kidney failure, prostate/ovarian cancer)	Y	N	_____
Muscle / Joints (e.g. weakness, arthritis)	Y	N	_____
Endocrine (e.g. diabetes, hypo- or hyper-thyroid)	Y	N	_____
Skin (e.g. rash, dryness)	Y	N	_____
Cardiovascular (e.g. high blood pressure, stroke, heart)	Y	N	_____
Neurologic (e.g. tingling, numbness, headaches)	Y	N	_____
Respiratory (e.g. shortness of breath, asthma)	Y	N	_____
Psychiatric (e.g. depression, memory loss)	Y	N	_____
Gastrointestinal (e.g. stomach pain, diarrhea, constipation)	Y	N	_____
Allergies/ Immunologic (e.g. hayfever, HIV)	Y	N	_____

Family Medical History

Circle Y, N or ? to note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

<u>DISEASE/CONDITION</u>	<u>YES</u>	<u>NO</u>	<u>UNSURE</u>	<u>RELATIONSHIP TO YOU</u>
Blindness	Y	N	?	_____
Cataract	Y	N	?	_____
Crossed Eyes	Y	N	?	_____
Glaucoma	Y	N	?	_____
Macular Degeneration	Y	N	?	_____
Retinal Detachment/Disease	Y	N	?	_____
Arthritis	Y	N	?	_____
Cancer	Y	N	?	_____
Diabetes	Y	N	?	_____
Heart Disease	Y	N	?	_____
High Blood Pressure	Y	N	?	_____
Kidney Disease	Y	N	?	_____
Cholesterol	Y	N	?	_____
Thyroid Disease	Y	N	?	_____
Other	Y	N	?	_____

Social History

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

Yes, I would prefer to discuss my Social History information directly with the Doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe below:

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

PAYMENT AUTHORIZATION

I authorize the payment of any eye care benefits or medical insurance to my Doctor of Optometry. I understand that I may have co-payments, deductibles, and overage costs, and ultimately I am responsible for all fees incurred.

Print Patient Name _____

Signature of Patient (or parent/guardian for minors) _____

Drs. Signature _____

Date _____