EYE CARE OF CLAREMORE

PATIENT INFORMATION

Mr. Mrs. Ms. ____________________ Today's Date: __________

Address: ____________________ Home Phone: __________

City: __________ State: _____ Zip: _____ Birth Date: ____/____/____

Marital Status: M S Sex: M F Last Eye Exam: __________

Social Security #: ______/_____/________ Cell Phone: __________

E-mail Address: ____________________ Texting? ☐ Yes ☐ No

EMPLOYER

Name: ____________________ Work Phone: __________

Can We Call You At Work? ☐ Yes ☐ No Occupation: __________

SPOUSE OR RESPONSIBLE PARTY

Name: ____________________ Home Phone: __________

Relationship to Patient: ____________________ Work Phone: __________

Social Security #: ______/_____/________ Birth Date: ____/____/____

INSURANCE INFORMATION

Please give all insurance cards and information to receptionist.

In Case of Emergency contact: ____________________ Phone: __________

Medical History

Name of Primary Care Physician: ____________________ Doctor's Phone #: __________

Last Eye Doctor: ____________________

Do you have any allergies to medications? ☐ No ☐ Yes

If Yes, explain: ____________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

List any eye medications or eye drops you are currently taking: ____________________

____

List all major injuries, surgeries, and/or hospitalizations you have had: ____________________

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: ____________________

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Medical History Questionnaire

Patient Name:______________________________

PERSONAL and SOCIAL HISTORY: Referred By:____________________ Referring Doctor:____________________

Relatives that are patients: ____________________ Hobbies:____________________

Interested in Contact Lenses?________ Ever Worn Contact Lenses?________ Primary Vision Correction ____________________

Type of Contact Lenses worn in past?____________________ Interested in Laser Vision Correction?__________

MEDICAL PERSONAL AND FAMILY HISTORY:

Patient Review of Systems: Do you currently or have you ever had any problems in the following areas?

(CHECK HERE IF ALL ANSWERS ARE NO) ☐ NO

System		
CONSTITUTIONAL: Fever, Weight Loss/Gain	☐ NO	☐ YES
INTEGUMENTARY (Skin):	☐ NO	☐ YES
NEUROLOGICAL: Migraines, Seizures	☐ NO	☐ YES
ENDOCRINE: Thyroid/Other Glands	☐ NO	☐ YES
EARS, NOSE, MOUTH, THROAT: Allergies, Chronic Cough	☐ NO	☐ YES
RESPIRATORY: Asthma, Chronic Bronchitis, Emphysema	☐ NO	☐ YES
VASCULAR/CARDIOVASCULAR: Diabetes, High Blood Pressure	☐ NO	☐ YES
GASTROINTESTINAL: Diarrhea, Constipation, Itching	☐ NO	☐ YES
GENITOURINARY: Kidney/Bladder	☐ NO	☐ YES
BONES/JOINTS/MUSCLES: Rheumatoid Arthritis, Joint Pain	☐ NO	☐ YES
LYMPHATIC/HEMATOLOGIC: Anemia Glare / Light Sensitivity	☐ NO	☐ YES
ALLERGIC/IMMUNOLOGIC	☐ NO	☐ YES
PSYCHIATRIC:	☐ NO	☐ YES

Are you pregnant and/or nursing? ☐ NO ☐ YES

EYES:		
Drooping Eye Lid	☐ NO	☐ YES
Loss of Vision	☐ NO	☐ YES
Blurred Vision	☐ NO	☐ YES
Distorted Vision/ Halos	☐ NO	☐ YES
Lazy Eye	☐ NO	☐ YES
Loss of Side Vision	☐ NO	☐ YES
Double Vision	☐ NO	☐ YES
Dryness	☐ NO	☐ YES
Mucous Discharge	☐ NO	☐ YES
Redness	☐ NO	☐ YES
Sandy or Gritty Feeling	☐ NO	☐ YES
Itching	☐ NO	☐ YES
Burning	☐ NO	☐ YES
Foreign Body Sensation	☐ NO	☐ YES
Excess Tearing / Watering	☐ NO	☐ YES
Glare / Light Sensitivity	☐ NO	☐ YES
Eye Pain or Soreness	☐ NO	☐ YES
Chronic Infection of Eye or Lid	☐ NO	☐ YES
Sties or Chalazion	☐ NO	☐ YES
Flashers / Floaters in Vision	☐ NO	☐ YES
Tired Eyes	☐ NO	☐ YES
Eye Injury	☐ NO	☐ YES

If you answered YES to any of the above or have a condition not listed, please explain:

____

____

____

____

Please note any family history (self, parents, siblings, children; living or deceased) for the following:

Disease/Condition:			Relationship to you:
Blindness	☐ NO	☐ YES	________
Cataract	☐ NO	☐ YES	________
Crossed Eyes	☐ NO	☐ YES	________
Glaucoma	☐ NO	☐ YES	________
Macular Degeneration	☐ NO	☐ YES	________
Retinal Detachment Disease	☐ NO	☐ YES	________
Arthritis	☐ NO	☐ YES	________
Cancer	☐ NO	☐ YES	________

Disease/Condition			Relationship to you:
Diabetes	☐ NO	☐ YES	________
Heart Disease	☐ NO	☐ YES	________
High Blood Pressure	☐ NO	☐ YES	________
Kidney Disease	☐ NO	☐ YES	________
Lupus	☐ NO	☐ YES	________
Thyroid Disease	☐ NO	☐ YES	________
Other	☐ NO	☐ YES	________

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

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 directly with my doctor. (Check box)

Do you use tobacco products? ☐ NO ☐ YES If yes, amount / how long?____________________

Do you drink alcohol? ☐ NO ☐ YES If yes, amount / how long? ____________________

Do you drive? ☐ NO ☐ YES Do you have visual difficulty when driving? If so, please describe____________________