Eye Care of Claremore

Patient Demographics

Patient Information: (Please Print)

Patient Name____ MI_________ Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____ Sex: Male ☐ Female ☐ Social Security Number: _____/_____/_____

Mailing Address: ____

City: ____ State: _______ Zip: ______________________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone ___________________

Email Address: ____

Communication Preference: ☐ Mail ☐ Email ☐ Text ☐ Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Language: ______________________________ Race/Ethnicity: ______________________________

In Case of Emergency Contact: _______________________ Relationship: ______________ Phone: ___________

Please list any relatives that are currently patients: ____

Hobbies Include: ____

Is patient interested in contact lenses? ☐ YES ☐ NO Has patient ever worn contact lenses? ☐ YES ☐ NO

If you answered yes, what type of contact lenses have you worn? ____

What is your primary vision correction? _____________ Are you interested in Laser Vision Correction? ☐ YES ☐ NO

Education and/or Employment Information: (Please fill out what applies to you in this section)

☐ Patient is a Student Name of School: ____

☐ Employed ☐ Unemployed *(If employed, please answer questions below)*

Employer/Company Name: ______________________________ Occupation: ______________________________

Insurance Information: (Please give all insurance cards and information to receptionist.)

Is patient the Primary Policy Holder? ☐ YES ☐ NO *(If no, please answer questions below)*

Primary Policy Holder Name: ____________________________________ Cell Number: _____________________

Employer/Company Name: _____________________________________ Work Phone: ______________________

Relationship to Patient: ____

Primary Policy Holder: Date of Birth: _____/______/______ Social Security Number: ______/_____/_____

MEDICAL PERSONAL AND FAMILY HISTORY:

PATIENT NAME: ______________________________ Current Height: ________ Weight: ________ Most Current Blood Pressure Reading ________

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)

MEDICAL:

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 OR NURSING	☐ NO	☐ YES

EYES:

Drooping Eye Lid	☐ NO	☐ YES
Loss of Vision/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/Redness	☐ NO	☐ YES
Sandy or Gritty Feeling	☐ NO	☐ YES
Itching/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	☐ NO	☐ YES
Sties or Chalazion	☐ NO	☐ YES
Flashes / Floaters in Vision	☐ NO	☐ YES
Eye Injury	☐ NO	☐ YES

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

Primary Care Physician :____________________________ Physician Phone: ____________________ Last Eye Doctor ____________________________

List any medications you are currently taking (including oral contraceptives, aspirin, over the counter, etc): ____________________________________

____

____

List any allergies to medications:____

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

List all major injuries, surgeries, and/or hospitalizations: ______________________________

____

____

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 Eye	☐ 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 information 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 ______________________________