Hamburg Family Eye Care

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	Nickname:
Home Address:			City, ST, Zip:
Phone: (check preferred) ❑ Hm:	❑ Cell:		❑ Wk:
Email Address:	DOB:	Sex: ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Other
SS#:	Employer/School:		Occupation/Grade:
Billing Address (if different):			
Why did you choose our office? ❑ Website ❑ Location ❑ Ins. Plan ❑ Other ❑ Referred by:			
Parents/guardians if patient is a minor			Other family members seen at this office:
Primary Physician:			Practice Name and Phone:
Previous Eye Doctor:			Address and/or phone (if CL RX or records of a medical condition are needed)
Race: ❑ Asian ❑ Black/African American ❑ Pacific Islander ❑ Native American/Alaskan ❑ White ❑ Decline			
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Decline			Preferred Language: ❑ English ❑ Spanish

INSURANCE INFORMATION

Please note: Most "Vision" plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems such as conjunctivitis, dry eye, ocular injuries, cataracts, glaucoma, macular degeneration, sudden pain or vision loss or monitoring for ocular side effects of chronic diseases such as diabetes and hypertension fall under your medical insurance coverage, not your "vision" plan. Some Well Vision Plans will apply your benefits toward medical co-pay and deductibles and some do not. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.

Medical Insurance Carrier:	ID#		Policy/Group #
If the patient is NOT the insured, please fill out the following information for the INSURED:			
Name:	DOB:	SS #:	Patient's relation to insured: ❑ Spouse ❑ Child ❑ Other
Address (if different):			Phone:
Vision Plan:	ID#:		Policy/Group #:
If the patient is NOT the insured, please fill out the following information for the INSURED:			
Name:	DOB:	SS #:	Patient's relation to the insured: ❑ Spouse ❑ Child ❑ Other
Address (if different):			Phone:

John R. Smith, OD, MS and Lori J. Smith, OD

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General Medical History

Patient's Last Name:	First:	MI:	Date:

Home Address: City, ST, Zip:

Primary Physician/ Practice Name	Physician's Phone number	When was your last physical exam?

Check the box for any conditions that apply:

	You	Mom	Dad	Sib	Describe
Hypertension	☐	☐	☐	☐	
Thyroid disease	☐	☐	☐	☐	
Cardiovascular disease	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	

If ***YOU*** are diabetic, when were you diagnosed?	What was your last A1c level?

Check if applicable:	Do you live alone?
☐ I am pregnant ☐ I am nursing	☐ Yes ☐ No ☐ Assisted Living ☐ Nursing Home

Smoking history:	Alcohol use:
☐ Never ☐ Former smoker ☐ Some days ☐ Every day	☐ None ☐ Occasional ☐Social ☐ 1drink/day ☐ 2+drinks/day

List ALL major injuries or surgeries you have had and approx dates:

List any other medical conditions you have, including non-drug allergies:

List all Rx and over-the-counter medications you currently take:

List any vitamins or supplements you currently take:

List any drug allergies you have

Review of Systems- list any problems you are currently having anywhere, from head to toe:

General (e.g., fever, fatigue, loss of appetite, unexplained weight loss/gain)

Ear, Nose, Throat (e.g., sinus problems, post-nasal drip, runny nose, dry mouth/throat, sleep apnea, hearing problems)

Cardiovascular (e.g., chest pain, racing heartbeat, swollen feet/ankles, cholesterol)

Respiratory (e.g., chronic cough/bronchitis, asthma, COPD, emphysema, shortness of breath, wheezing)

Genital, Kidney, Bladder (e.g., bladder/urinary problems, pain, menstrual changes, impotence)

Gastrointestinal (e.g., crohn's disease, ulcerative colitis, gastric reflux (GERD))

Endocrine (e.g., heat or cold intolerance, thinning hair, excess thirst, excess urination)

Muscles, Bones, Joints (e.g., joint pain, muscle pain,stiffness, weakness, limited movements, rheumatoid arthritis, osteoarthritis)

Skin (e.g., eczema, psoriasis, rash, rosacea)

Neurological (e.g., headaches, migraines, seizures, numbness, dementia, concussions, vertigo, poor balance, strokes(TIAs), MS)

Psychiatric (e.g., depression, anxiety, bi-polor, sleep problems, paranoia, obsessive/compulsive, attention issues(ADHD))

Blood/Lymph (e.g., anemia, bleeding problems, delayed clotting)

Allergy/Immune (e.g., itching, sneezing, runny nose/eyes, guillian-barre syndrome, lupus)

Ocular History

Name:	Date:
Who was your previous eye doctor?	When was your last eye exam?

Check any conditions that apply:

	You	Mom	Dad	Sib	Describe
Glaucoma	☐	☐	☐	☐	
Macular Degeneration	☐	☐	☐	☐	
Retinal problems	☐	☐	☐	☐	
Cataracts	☐	☐	☐	☐	
Lazy eye/Eye turn	☐	☐	☐	☐	

List major EYE injuries, infections or surgeries and approx dates

List any other eye problems you have had in the past

List any EYE drops you use (Rx or OTC)

List any vision complaints you are having such as:

- blurred vision, headaches, eyestrain, double vision or losing your place when reading;
- itching, burning, redness, sensitivity to light, watering, crusting or mucus discharge;
- seeing dark spots, squiggles or webs, bright flashes or colored rainbows around lights at night;

Explain:

How many hours/day do you typically spend using a computer or other digital devices?

If you're having complaints with computer work, how far is the monitor from your eyes?

How many hours/day do you typically spend reading books, magazines, etc?

What are your hobbies?	Do you wear glasses?	How old are your glasses?

Do you have sunglasses?	Do you have back-up glasses?	Are you are interested in contacts lenses?

Contact Lens Wearers Only

What disinfecting solution do you use?

How long do you wear your contact lenses?

How often do you replace your contact lenses?	When you replace them, are the new lenses noticeably clearer or more comfortable?

How old is your current pair of contacts lenses?

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