GREELEY EYECARE CENTER

Last Name_____ First_____ MI_____
Address_____ City_____ State_____ Zip_____
Date of Birth_____ Social Security #_____
Home Phone_____ Work/Cell Phone_____ Email_____
Occupation_____ Employer_____
Grade if Student_____ School_____

INSURANCE INFORMATION

VISION INSURANCE PROVIDER_____
Subscribers Name_____ Subscriber SS#_____ DOB_____

MEDICAL INSURANCE PROVIDER_____
Subscribers Name_____ Subscriber SS#_____ DOB_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

Family/friend Insurance List Yellow Pages Internet Location
Who may we thank for referring you to our office?_____

MEDICAL HISTORY & REVIEW OF SYSTEMS

GENERAL

What is the major purpose of this visit?_____

Will you be updating your eyeglasses today?	Y	N	If needed
Are you interested in Laser Vision Correction?	Y	N	
Are you interested in contact lenses if not currently wearing any?	Y	N	
Would you be interested in contact lenses that you could sleep in?	Y	N	

OCULAR HISTORY

Date of last eye exam_____ By whom?_____
Do you currently wear eyeglasses? Y N
Do you currently wear contact lenses? Y N Soft Hard Brand name_____
Brand of solution used_____
If you wear contact lenses, are you satisfied with the vision and comfort? Y N
List any past eye surgeries, injuries or disease_____

MEDICAL HISTORY

Family Physician_____
General health status ___Excellent ___Good ___Fair ___Poor Height_____ Weight_____
Current medications (Rx and OTC)_____
_____
Medication drug allergies _____

FAMILY HISTORY

Please indicate if any family member has had these conditions:

			Relationship to you
Blindness	Y	N	_____
Cataract	Y	N	_____
Glaucoma	Y	N	_____
Macular Degeneration	Y	N	_____
Diabetes	Y	N	_____
High Blood Pressure	Y	N	_____
Cancer	Y	N	_____
Heart Disease	Y	N	_____
Arthritis	Y	N	_____
Thyroid Disease	Y	N	_____
Stroke	Y	N	_____

SOCIAL HISTORY

Marital status ___Single ___Married ___Divorced ___Widow/Widower

Employment status ___Employed ___Self-employed ___Homemaker ___Retired
___Medical disability ___Unemployed

Do you use tobacco products? Y N packs per week_____

Do you drink alcohol? Y N how often?_____

REVIEW OF SYSTEMS

Please indicate if YOU currently have any problems in one or more of the following areas

ALLERGY Y N_____
(reactions to drugs, food, insects, skin rashes)

CARDIOVASCULAR Y N_____
(hypertension, heart problems, fainting)

CONSTITUTIONAL Y N_____
(fever, weight loss or gain, tired feeling)

ENDOCRINE Y N_____
(diabetes, thyroid dysfunction, hormonal dysfunction)

GASTROINTESTINAL Y N_____
(diarrhea, constipation, heartburn, indigestion)

GENITOURINARY Y N_____
(painful urination, frequent urination, frequency, jaundice)

EARS, NOSE, THROAT, MOUTH Y N_____
(hearing loss, ear ache, congestion, cough, dry mouth)

HEMOTOLOGIC/LYMPHATIC Y N_____
(anemia, bleeding problems)

IMMUNOLOGIC Y N_____
(bleeding tendency, anemia, transfusions)

INTEGUMENTARY Y N_____
(excema, rosacea, psoriasis, rash, itching)

MUSCULOSKELATAL Y N_____
(joint pain, muscle pain, cramps, stiffness)

NEUROLOGIC Y N_____
(difficulty with memory/speech, tremors)

PSYCHIATRIC Y N_____
(anxiety, depression, hallucinations)

RESPIRATORY Y N_____
(asthma, emphysema, bronchitis, shortness of breath)