Last Name **First Name** **MI** Age: Date:

Personal Info

Address _____ State _____ Zip Code _____
City _____ ☐ Male ☐ Female
Home Phone (____)_____ Work Phone (____)_____
Date of Birth _____ Cell Phone (____)_____
SSN _____ Emergency Contact: _____
Occupation _____ Relationship: _____
Email _____ Emer. Contact #: _____
Wearing Now ☐Glasses ☐Contacts ☐Both ☐Neither Contact preference: ☐ Home ☐ Cell ☐ Work ☐ Email

Insurance

Vision Insurance

Insurance Name: _____
Policy/Member ID: _____
Prim. Insurer's Name: _____
Primary Insurer's ID: _____
Prim. Insurer's DOB: _____
Relationship: _____

Last Eye Exam: _____
Doctor: _____
Findings:

Health Insurance

Insurance Name: _____
Primary Member ID #: _____
Group #: _____
Primary Insurer's Name: _____
Primary Insurer's DOB: _____
Primary Insurer's SSC#: _____

Last Physical Exam: _____
Doctor: _____
Findings:

Medical History

Patient's Symptoms

Please mark all

☐ Blurred Vision
☐ Loss of Vision
☐ Distorted Vision/ Halos
☐ Double Vision
☐ Dry Eyes
☐ Mucous Discharge
☐ Redness
☐ Sandy or Gritty Feeling
☐ Itching Eyes
☐ Burning Eyes
☐ Irritation
☐ Watery Eyes
☐ Glare/ Light Sensitivity
☐ Eye Pain or Soreness
☐ Chronic Eye Infections
☐ Chronic Lid Infections
☐ Styes or Chalazion
☐ Tired Eyes
☐ Other _____
☐ Other _____

Patient and Family Medical History

Please mark all that apply to you or your family

	Self	Family
Eye		
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Strabismus (Eye Turn)	☐	☐
Amblyopia (LazyEye)	☐	☐
Nystagmus	☐	☐
Cataracts	☐	☐
Eye Injuries	☐	☐
Retinal Detachment	☐	☐
Constitutional		
Fever	☐	☐
Weight Loss/ Gain	☐	☐
Integumentary (Skin)		
	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Endocrine		
Thyroid	☐	☐
Other Glands	☐	☐
Ears, Nose, Throat		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/ Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular/ Cardio.		
Diabetes	☐	☐
Hypertension	☐	☐
Heart Pain	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Bones/ Joints/ Muscles		
Arthritis (Osteoarthritis)	☐	☐
Muscle or Joint Pain	☐	☐
Rheumatoid Arthritis	☐	☐
Lymphatic/ Hematology		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/ Immunology		
_____	☐	☐
Psychiatric		
_____	☐	☐
Other Medical		
HIV Positive	☐	☐
Head Trauma	☐	☐
Autoimmune Disease	☐	☐
Other _____	☐	☐

Meds

Please list all medications that you are currently taking:

Are you allergic to any medications:

Social History

☐ Y ☐ N Do you drink alcohol or use tobacco products? If Yes, what type/amount/how long: _____
☐ Y ☐ N Do you use illegal drugs? If Yes, what type/amount/how long:_____
☐ Y ☐ N Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis
☐ Y ☐ N Are you pregnant? Are you currently breastfeeding? ☐ Yes ☐ No
☐ Y ☐ N Do you have difficulties with your vision when driving?
☐ Y ☐ N Do you have difficulties with your vision at work?
☐ Y ☐ N **Are you interested in Contact Lenses?**
☐ Y ☐ N **Are you interested in Lasik?**

Sign

☐ I have read and understand the ***Notice of Privacy Practices***.
☐ I have read and understand ***What is the Dilation***. I am aware that the dilation is needed to examine the complete health of my eye.
☐ **I wish to have my eyes dilated**
☐ **I DO NOT want to have my eyes dilated**: EEC is not liable for any lens or retinal disease that cannot be observed.

Sign

_____ **Print Patient's Name**
_____ **Patient/Guardian Signature**
_____ **Date**

Reviewed *By:*