InSight EyeCare

Name_____ Today's Date_____

Address_____ Date of Birth_____ Age_____ Sex: M F

City_____State_____Zip_____ Marital Status: Single Married Divorced Widow(er)

Home phone_____ Spouse (or parent) name_____

Cell phone_____ Spouse (or parent) work phone_____

Work _____ How did you first hear about our office?

Employer (or school)_____ Referred by: Friend Relative Health Care Provider

Occupation (or grade)_____ If so, who? _____

E-mail address_____ Newspaper Event Social Media Other_____

Appointment reminders and notifications are sent via email. ***We will NOT share your email.***

Circle one in each category:

Race: White, Black, American Indian, Asian, African American, Alaska Native, Hawaiian, Pacific Islander, Decline to answer

What other family members are patients here?

_____

_____

Ethnicity: Hispanic/Latino, Not Hispanic/Latino, Decline to answer

Preferred Language: English or Other_____

Eye History

List all **eye** drops or **eye** medications you are currently using:_____

List any **eye** surgeries, injuries, or infections:_____

_____

Approximate date of last eye exam:_____

What is the major purpose of your visit to our office today? _____

Do you presently wear: (Circle all that apply)

☐**Glasses** ☐**Contacts, list type:**_____ ☐**Neither**

Any problems with your current glasses or contact lenses?_____

Are you interested in contact lenses? Yes No

List any hobbies/ recreational activities you are involved in:_____

List any occupational needs (ex. safety or computer glasses):_____

Do you have prescription sunglasses? Yes No

Do you have glare problems with night driving, computer use, or fluorescent lights? Yes No

Are you light sensitive? Yes No

Are you interested in Laser vision correction surgery? Yes No

PLEASE COMPLETE BOTH PAGES

General Medical History

Primary Care Physician:_____ Date of last visit:_____

Federal guidelines require the following: Height _____ Weight _____ Blood Pressure _____

Please list all **medications, vitamins, and supplements** you currently take:_____

_____

_____

Indicate conditions as they apply to you:			**Family History of conditions:**			If yes, relationship:
Glaucoma	Yes	No	Glaucoma	Yes	No	_____
Cataracts	Yes	No	Cataracts	Yes	No	_____
Macular Degeneration	Yes	No	Macular Degeneration	Yes	No	_____
Ocular Cancer	Yes	No	High blood pressure	Yes	No	_____
Eye Surgery	Yes	No	Diabetes	Yes	No	_____
High blood pressure	Yes	No				_____
Diabetes	Yes	No				_____
Cholesterol issues	Yes	No				

List all ALLERGIES (drug, environmental, and food):_____

CIRCLE any conditions below that apply to you: ☐ All Normal

Immune System
Lupus
Rheumatoid Arthritis

Circulatory/Heart
Heart disease
Hypertension
Stroke

Constitutional
Disability history
Trauma history
Sleep disorder

Ear/Nose/Throat/Mouth
Ringing/Tinnitus ears

Endocrine
Diabetes: NON or INSULIN dependent
Thyroid or Hormonal disorder

Gastrointestinal
Crohn's
Colitis
Stomach ulcer

Blood/Lymph
Anemia
Blood donor

Skin
Eczema
Rosacea
Psoriasis

Muscle/Bone
Fibromyalgia
Muscular dystrophy
Osteoarthritis

Neurological
Multiple Sclerosis
Epilepsy
Alzheimer's
Parkinson's

Psychiatric
Panic Disorder
Depression
Schizophrenia

Respiratory
Asthma
Emphysema
Smoker
Previous Smoker
Alcohol use
Other Substances

Please list any other conditions:_____

_____

List all major surgeries, injuries, or hospitalizations you have had:_____

_____