SHELBY FAMILY EYE CARE

Name:_____ Today's Date: _____

Address: _____ Date of Birth:_____

_____ Work Phone:_____

Parent/ Guardian (if applicable): _____ Cell Phone: _____

Email address: _____ Occupation: _____

How may we contact you? ☐ Phone ☐ Text ☐ Email ☐ All

Emergency Contact Name/Phone: _____

Name of Medical Doctor: _____ Last Eye Exam: _____

Who do we thank for referring you today? _____

Insurance Information:

Medical Insurance:

Primary Insurance Co: _____ ID#: _____ GRP #_____

Policy Holder Name: _____ SSN: _____

Policy Holder DOB: _____ Policy Holder Address: _____

Secondary Insurance Co: _____ ID#: _____ GRP _____

Policy Holder Name: _____ SSN: _____

Policy Holder DOB: _____ Policy Holder Address: _____

Vision Insurance:

Primary Insurance Co: _____ ID#: _____ GRP #_____

Policy Holder Name: _____ SSN: _____

Policy Holder DOB: _____ Policy Holder Address: _____

I certify that I have completed the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release information (including diagnosis and treatment) rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of the exam.

_____ _____

Signature of Patient or Parent/Guardian Date

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MEDICAL HISTORY

Do you have any allergies to medication? ☐ No ☐ Yes If yes, explain:_____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter and home remedies):

_____

_____

_____

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

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury: _____

Are you pregnant and/or nursing? ☐ No ☐ Yes If yes, have you been diagnosed with gestational diabetes? ___

SPECTACLE/CONTACT LENS HISTORY

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair?_____

What do you wear your glasses for? _____ Do you use a computer/phone/tablet more than 3 hours a day? _____ Are you happy with your current frames and lenses? _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, how old is your present pair?_____

What is the brand of your current contacts? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Other Are they comfortable? ☐ No ☐ Yes

Social History (*This information is strictly confidential! However, you may discuss this portion with the doctor if you prefer.)*

☐ *Yes, I would prefer to discuss my social history information directly with the doctor. (Check box)*

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

Please describe:_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long:_____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long:_____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ None

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	No	Yes	Unsure
EYES			
Poor vision	☐	☐	☐
Eye pain	☐	☐	☐
Tearing	☐	☐	☐
Redness	☐	☐	☐
Itching	☐	☐	☐
Jaw pain	☐	☐	☐
Scalp tenderness	☐	☐	☐
Spots in vision	☐	☐	☐
Loss of vision	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Chills	☐	☐	☐
Weight loss	☐	☐	☐
ENT AND MOUTH			
Stuffy nose	☐	☐	☐
Ear ache	☐	☐	☐
Cough	☐	☐	☐
Dry mouth	☐	☐	☐
CARDIOVASCULAR			
High blood pressure	☐	☐	☐
Rapid heart beat	☐	☐	☐
Heart attack/heart surgery	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Congestion	☐	☐	☐
Wheezing	☐	☐	☐
Shortness of breath	☐	☐	☐
GASTROINTESTIAL			
Upset stomach	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
IBS	☐	☐	☐

GENITOURINARY			
Burning on Urination	☐	☐	☐
Urinary Frequency	☐	☐	☐
Incontinence	☐	☐	☐
BPH	☐	☐	☐
BONES/JOINTS/MUSCLES			
Joint pain	☐	☐	☐
Stiffness	☐	☐	☐
Arthritis	☐	☐	☐
Integumentary			
Rash	☐	☐	☐
Changing moles	☐	☐	☐
Neurological			
Headache	☐	☐	☐
Seizure	☐	☐	☐
Stroke	☐	☐	☐
Paralysis	☐	☐	☐
Psychiatric			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Insomnia	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid abnormalities	☐	☐	☐
Hematologic / Lymphatic			
Bleeding	☐	☐	☐
Anemia	☐	☐	☐
Allergic/ Immunologic			
Allergies	☐	☐	☐
Hay fever	☐	☐	☐

SHELBY FAMILY EYE CARE

FAMILY HISTORY

Please note any family history (parents, grandparenets, siblings, children, living or deceased) for the following:

	No	Yes	Unsure	Relationship to you
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes (lazy eye)	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____