Family Vision Clinic

Dr. Mike E. Harris   Dr. Nathan D. Edwards

patient information

today's date: ....

name: .... age: .... date of birth: ....

social security number: .... gender: ○ male ○ female

address: ....

....

mailing address: ....

....

residence phone: .... cell phone: .... work phone: ....

email address: ....

Is it okay to contact you via email? ○ yes ○ no

occupation: .... employer: ....

are you: ○ single ○ married ○ divorced ○ widowed

Is any other family member a patient in this office? ....

Whom may we thank for your referral? ....

Who is responsible for payment of services? ....

Please list payer's contact information if different from the patient:

mailing address: ....

....

residence phone: .... cell phone: .... work phone: ....

previous eye care professional: .... date of last exam: ....

name of medical doctor: .... date of last exam: ....

main reason for your visit today: ....

Do you wear or are you interested in: ○ glasses ○ contact lenses ○ laser vision correction

If yes, please specify: ....

....

type of contact lenses: ○ soft ○ rigid ○ other *Are they comfortable?* ....

Are you currently pregnant? ○ yes ○ no Are you currently nursing? ○ yes ○ no

Do you use tobacco products? ○ yes ○ no *If yes, type/amount/how often?* ....

Do you drink alcohol? ○ yes ○ no *If yes, type/amount/how often?* ....

Do you use illegal drugs? ○ yes ○ no *If yes, type/amount/how often?* ....

medical history (personal and family)

OCULAR

Crossed Eyes ○ self ○ family *relationship to you:* ....

Lazy Eye ○ self ○ family *relationship to you:* ....

Cataract ○ self ○ family *relationship to you:* ....

Glaucoma ○ self ○ family *relationship to you:* ....

Macular Degeneration ○ self ○ family *relationship to you:* ....

Retinal Disease ○ self ○ family *relationship to you:* ....

Other: .... ○ self ○ family *relationship to you:* ....

Have you ever had any type of eye injury or surgery? ○ yes ○ no *If yes, explain:* ....

....

CARDIOVASCULAR

Heart Disease ○ self ○ family *relationship to you:* ....

High Blood Pressure ○ self ○ family *relationship to you:* ....

Heart Attack ○ self ○ family *relationship to you:* ....

Stroke ○ self ○ family *relationship to you:* ....

ENDOCRINE

High Cholesterol ○ self ○ family *relationship to you:* ....

Diabetes ○ self ○ family *relationship to you:* ....

Kidney Disease ○ self ○ family *relationship to you:* ....

Thyroid Disease ○ self ○ family *relationship to you:* ....

GASTROINTESTINAL

GERD ○ self ○ family *relationship to you:* ....

Chron's Disease ○ self ○ family *relationship to you:* ....

Liver Disease ○ self ○ family *relationship to you:* ....

HEMATOLOGIC/LYMPHATIC

Anemia ○ self ○ family *relationship to you:* ....

Clotting Disorder ○ self ○ family *relationship to you:* ....

Sickle Cell ○ self ○ family *relationship to you:* ....

IMMUNOLOGIC

Herpes Simplex ○ self ○ family *relationship to you:* ....

Herpes Zoster ○ self ○ family *relationship to you:* ....

HIV/AIDS ○ self ○ family *relationship to you:* ....

Sarcoidosis ○ self ○ family *relationship to you:* ....

SKIN

Rosacea ○ self ○ family *relationship to you:* ....

Albinism ○ self ○ family *relationship to you:* ....

MUSCULOSKELETAL

Condition	Self	Family	Relationship
Arthritis	○ self	○ family	*relationship to you:* ....
Ankylosing Spondylitis	○ self	○ family	*relationship to you:* ....
Myasthenia Gravis	○ self	○ family	*relationship to you:* ....

NEUROLOGICAL

Condition	Self	Family	Relationship
Headache/Migraine	○ self	○ family	*relationship to you:* ....
Acquired Brain Injury	○ self	○ family	*relationship to you:* ....
Multiple Sclerosis	○ self	○ family	*relationship to you:* ....

PSYCHIATRIC

Condition	Self	Family	Relationship
Attention Disorder	○ self	○ family	*relationship to you:* ....
Alzheimer's	○ self	○ family	*relationship to you:* ....
Depression	○ self	○ family	*relationship to you:* ....

RESPIRATORY

Condition	Self	Family	Relationship
Asthma	○ self	○ family	*relationship to you:* ....
Cystic Fibrosis	○ self	○ family	*relationship to you:* ....
Emphysema	○ self	○ family	*relationship to you:* ....

please list any other condition(s) not found above: ....

....

....

....

....

please list medications currently taken: ....

....

....

Do you have any allergies to medications? ○ yes ○ no *If yes, explain:* ....

....

Do you have any other allergies (ie., environmental/seasonal)? ○ yes ○ no *If yes, explain:* ....

....

I understand that payment is due when services are rendered.

PATIENT SIGNATURE: .... DATE: ....