Elite Eye Care

Patient Information

Last Name

First Name MI

Address

City State Zip

Date of Birth Age Sex ☐ M ☐ F

Patient's SSN

Ethnicity: (Optional) ☐ African American

☐ American Indian ☐ Asian ☐ Hispanic/Latino

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Home Phone

Work Phone

Cell Phone May we text you ☐ Yes ☐ No

Email (Please include an email address so we can begin confirming appointments via email)

_____

May we leave you voicemails ☐ Yes ☐ No

Employer

Occupation

School Name

Grade

Are you having any problems with your current eyeglasses/contact lenses? ☐ Yes ☐ No

If Yes, please explain:

_____

_____

_____

Patient Medical History

Family Physician_____

Address _____

Phone _____

Pharmacy _____

Location _____

Phone _____

Have you ever been diagnosed or treated for the following health problems?

☐ Fatigue Syndrome
☐ Cancer
☐ Developmental Disorder
☐ Laryngitis
☐ Sinusitis
☐ Hearing Loss
☐ Multiple Sclerosis
☐ Stroke
☐ Epilepsy
☐ Depression
☐ High Blood Pressure
☐ Vascular Disease
☐ Congestive Heart Failure
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ Latex Sensitivity
☐ Ulcer
☐ Acid Reflux
☐ Prostate Disease
☐ Kidney Disease
☐ Muscular Dystrophy
☐ Arthritis
☐ Fibromyalgia
☐ Eczema
☐ Thyroid
☐ Diabetes
☐ Blood Loss
☐ Ulcer
☐ Anemia
☐ Environmental Allergies
☐ Rheumatoid Arthritis
☐ Other

Current Medications: (RX or over the counter) List name of medications including eye drops, vitamins & birth control

_____

_____

_____

Allergies to Medications ☐ Yes ☐ No

If yes, what medications are you allergic to?

_____

Patient Eye History

Date of Last Eye Exam_____

By Whom _____

Do you wear: ☐ Eyeglasses ☐ Contact Lenses

If contacts, what kind are you currently using?

_____

What type of solution are you using?

_____

Are you satisfied with the vision and comfort of your contact lenses?

☐ Yes ☐ No

If eyeglasses, and are wearing bifocals, do the lines or head tilting bother you? ☐ Yes ☐ No

Have you ever experienced, been diagnosed or treated for any of the following?

☐ Eye Surgery
☐ Patching
☐ Glaucoma
☐ Glaucoma Suspect
☐ Macular Degeneration
☐ Eye Injury
☐ Lazy Eye
☐ Burning
☐ Inflammatory Disorder
☐ Floaters/Spots
☐ Retinal Degeneration
☐ Double Vision
☐ Retinal Hole
☐ Occasional Dryness
☐ Cataract
☐ Trouble Seeing at Night
☐ Sunlight/Light Sensitivity

Family History

Is there a family medical history of any of the following?

(Check all that apply) Please list family member:

☐ Thyroid _____
☐ Diabetes _____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ Cancer _____
☐ Lazy Eye _____
☐ Cataract _____
☐ Glaucoma _____
☐ Retinal Problems _____
☐ Macular Degeneration _____
☐ Blindness _____
☐ Corneal Problems _____

Do you use alcohol? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Tobacco Use: ☐ Cigars ☐ Cigarettes ☐ Other ☐ Smokeless Tobacco