Patient Information and History

Welcome to Eyecare Associates of Prescott: Today's Date ___________

Patient Name _______________________________________ SSN/Ins.I.D.# ___________________________

Email _________________________________ Employer____

How did you hear about us? Yellow pages ___ Newspaper ___ Insurance ___ Welcome Neighbor ___
Website ___ Referral from ___________________ other _____________________

Reason for today's visit ______________________ Date of last exam ___________Dr. __________________

Your estimate of your overall general health : Excellent Good Fair Poor

Do you or someone in your immediate family have a **history** of the following?

	No	Self	Family	
High Blood Pressure	☐	☐	☐	____________
Diabetes	☐	☐	☐	____________
Glaucoma	☐	☐	☐	____________
Cataract	☐	☐	☐	____________
Macular Degeneration	☐	☐	☐	____________
Blindness	☐	☐	☐	____________
Thyroid problems	☐	☐	☐	____________
Frequent Headaches	☐	☐	☐	____________
Allergies	☐	☐	☐	____________
Sinus trouble	☐	☐	☐	____________
Currently Pregnant	☐	☐	☐	____________
Recent childbirth	☐	☐	☐	____________
Drug Allergies	☐	☐	☐	____________

Do you have any problems with any of these **systems** in your body?

	No	Yes	
Cardiovascular	☐	☐	______________
Respiratory/Lung	☐	☐	______________
Allergic/Immune	☐	☐	______________
Blood/Lymphatic	☐	☐	______________
Endocrine/Hormone	☐	☐	______________
Skin	☐	☐	______________
Musculoskeletal	☐	☐	______________
Ear/Nose/Throat	☐	☐	______________
Neurological	☐	☐	______________
Psychiatric	☐	☐	______________
Gastrointestinal	☐	☐	______________
Genitourinary	☐	☐	______________

List the **MEDICATIONS** you are currently taking: ____

____

Confidential **Social** History: Do you: Use tobacco: Y / N Drink Alcohol: Y / N Use Illegal Drugs Y / N

If Yes above, list type/amount/how long: ____

Have you ever had any of the following conditions involving **your eyes**?

	No	Yes	
Poor distance vision	☐	☐	____________
Poor near vision	☐	☐	____________
Double Vision	☐	☐	____________
Eye injury or surgery	☐	☐	____________
Eye infection / disease	☐	☐	____________
Dry or Scratchy Eyes	☐	☐	____________
Floaters/spots	☐	☐	____________
Sensitivity to light	☐	☐	____________
Eye strain	☐	☐	____________
Eyes itch, burn, or water	☐	☐	____________

To help us serve you better: Your Occupation:____

- Does your work or hobby require you to **focus** at a variety of distances? Y N
- Is **night driving, headlight glare**, or **ghost images** a concern of yours? Y N
- Does road surface, snow, water, or window **glare** ever create problems for you? Y N
- Are you aware of the danger of **ultra-violet** light on your eyes? Y N
- Do you operate a **computer**? How many hours each day?_________________ Y N

CIRCLE your **Sports**: Jog, Ski, Tennis, Swim, Golf, Racquet Ball, Fishing, Hunting, Hiking, Biking, Other ______________________

CIRCLE your **Hobbies:** Musical Instrument, Painting, Crafts, Cards, Flying, Woodworking, Other ______________________

Dr. rev.