

Patient Information and History

Welcome to Premier Eye Center:

Today's Date _____

Patient Name _____ SSN/Ins.I.D.# _____

Email _____ Employer _____ Primary Care Provider (PCP/GP) _____

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

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

	No	Yes		No	Yes
Poor distance vision	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Poor near vision	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Eye injury or surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Floater / spots	<input type="checkbox"/>	<input type="checkbox"/>	_____		
			Dry or scratchy eyes	<input type="checkbox"/>	<input type="checkbox"/>
			Red or uncomfortable	<input type="checkbox"/>	<input type="checkbox"/>
			Eyes itch, burn or water	<input type="checkbox"/>	<input type="checkbox"/>
			Eye strain	<input type="checkbox"/>	<input type="checkbox"/>
			Fluctuating vision	<input type="checkbox"/>	<input type="checkbox"/>

Do you ever use or feel the need to use eye **drops**? What kind/brand? How often?

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

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

	No	Self	Family	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent childbirth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Drug Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	No	Yes
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory/Lung	<input type="checkbox"/>	<input type="checkbox"/>
Allergic/Immune	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Hormone	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Ear/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

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: _____

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
- Do you operate a **computer**? How many hours each day? _____

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

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

Dr. rev.