

WELCOME TO INSIGHT EYECARE

Patient Information

Name _____ Sex: M/F _____ Today's Date: _____
Last First MI

Address _____ City _____ State _____ Zip _____

Home phone# _____ Work phone# _____ Ext: _____ Date of Birth: _____ Age _____

How did you hear about us? _____ SS# _____ Race: _____

Marital Status: (Please circle one) S M D W Contact in case of an Emergency: _____

Party Responsible for Acct: _____ Date of Birth _____ SS# _____

Insurance Company _____ Policy# _____ Group# _____

Employer: _____ Occupation _____ Phone # for Contact: _____

Cell Phone number _____ E-Mail Address _____

Medications (Prescriptions or over the counter)

Allergic to Medication? _____ Name of Current Medications _____
No Yes

If Yes Please List: _____

Name of Physician: _____

Eye Medical History

CONDITION	NO	YES	
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family Medical History

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

CONDITION	NO	YES	RELATIONSHIP
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other			_____

Do You.....

Work at a computer for long periods? No Yes

Have more than one pair of glasses? No Yes

Want information on thinner, lighter lenses? No Yes

Wear bifocal:
 If yes, are you bothered by head tilting, restricted areas of vision correction, etc.? No Yes

Always like to wear your glasses? No Yes

Spend time outdoors? If so how much? _____ hrs/wk

Have prescription sunglasses No Yes

Have problems with glare or reflection, particularly when driving at night? No Yes

Special hobbies or recreational activities: _____

Are you interested in refractive surgery? No Yes

Have you ever worn or are you currently wearing contacts? No Yes

If yes: what kind _____ Solutions used _____

Are you interested in contact lenses? No Yes

Do you experience.....(Please check appropriate boxes)

<input type="checkbox"/> Burning	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Watery eyes
<input type="checkbox"/> Tearing	<input type="checkbox"/> Dryness	<input type="checkbox"/> Soreness
<input type="checkbox"/> Redness	<input type="checkbox"/> Eye strain	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Headaches	<input type="checkbox"/> Nausea	<input type="checkbox"/> Gritty feeling in eyes
<input type="checkbox"/> Fainting or Dizziness	<input type="checkbox"/> Sudden loss of vision	
<input type="checkbox"/> Blurred distance vision	<input type="checkbox"/> Blurred near vision	
<input type="checkbox"/> Objects floating in vision	<input type="checkbox"/> Spots	
<input type="checkbox"/> Flashes of Lights	<input type="checkbox"/> Sensitivity of light	
<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Glare or reflections	
<input type="checkbox"/> Trouble working up-close	<input type="checkbox"/> Reading Problems	
<input type="checkbox"/> Trouble learning at work, school or other activities		
<input type="checkbox"/> Uncomfortable contact lenses		
<input type="checkbox"/> Uncomfortable glasses		
<input type="checkbox"/> Other: _____		

PLEASE COMPLETE SIDE TWO

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor.*

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

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes If 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

Review of Systems Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications)

	NO	YES	?	EXPLAIN/LIST MEDICATIONS
CONSTITUTIONAL (fever, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGICAL				
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT				
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR/CARDIOVASCULAR				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES/JOINTS/MUSCLES				
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC/HEMATOLOGIC				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE (thyroid/other glands)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC (anxiety, depression, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Doctor's Signature: _____

Date: _____