ADVANCEDFAMILY EYE CARE

400 7th St. Ellwood City
214 W. New Castle St. Zelienople

PATIENT INFORMATION

Last Name _____

First Name _____ MI_____

Street _____

City _____

State _____ Zip Code _____

Cell Phone _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Employer/School _____

Occupations/Grade _____

Spouse/Parent's Name _____

Spouse/Parent's Workplace _____

Date of Birth _____ Age_____

Sex: Male Female

Email Address _____

Whom should we notify in case of an emergency?

_____
(name) (telephone) (relationship)

What is the primary purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

LIFESTYLE QUESTIONS

Do you…(check box if your answer is yes)

- ☐ work at a computer? How much?_____Hrs/day
- ☐ think you might benefit from thinner, lighter lenses?
- ☐ have interest in trying the latest contact lenses?
- ☐ spend time outdoors? How much?_____Hrs/week
- ☐ have prescription sunwear?
- ☐ prefer not to wear your glasses?
- ☐ want information on Laser Vision Correction surgery?
- ☐ have interest in a non-surgical vision correction?
- ☐ have more than one pair of current Rx eyewear?
- ☐ have children?
- ☐ have family members in need of eyecare?

Whom may we thank for referring you to our office?

Name of friend or relative? _____

If not referred, how did you choose our office?

Another Dr._____
Insurance Company
Saw Sign/Building
Yellow Pages
Web Page
Other _____

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary **Medical** Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

I understand that I am responsible for any charges not covered by my medical or vision insurance:

_____
(Signature) Date

MEDICAL HISTORY

List Current Medications:

_____

_____

_____

_____

Allergy Information

Drug Allergies _____

Food/Environmental _____

Last Eye Exam _____

Medical Dr.'s Name _____

Medical Dr.'s Phone _____

Any known eye disease? _____

Eye injury or surgery? _____

FAMILY HISTORY (check all that apply):

Blindness	_____	Cataracts	_____
Glaucoma	_____	Crossed Eyes	_____
Macular Degeneration	_____	Diabetes	_____
Retinal Detachment	_____	Arthritis	_____
Kidney Disease	_____	Heart Disease	_____
High Blood Pressure	_____	Cancer	_____
Thyroid Disease	_____	Lupus	_____

Other _____

Social History

Are you a smoker? Yes or No

Former Smoker? Yes or No How long ago?_____

Height _____ Weight _____

Do you currently have, or have you ever had any problems in the following area?
Please Circle

Constitution

Fatigue Syndrome Developmental Disability

Ears, Nose, Mouth, Throat

Hearing Loss Allergies/Hay Fever
Sinusitis

Neurological

Headaches Migraines Stroke/CVA
MS Epilepsy Seizures

Psychiatric

Depression Anxiety Bipolar
ADHD

Cardiovascular/Vascular

Heart Failure Vascular Disease
High Blood Pressure Heart Disease

Respiratory

Asthma COPD Emphysema
Bronchitis Sleep Apnea

Gastrointestinal

Acid Reflux Crohns/Colitis
Ulcer Celiac Disease

Genitourinary

BPH Prostate Cancer
Kidney Disease

Musculoskeletal

Arthritis Gout Osteoporosis
Fibromyalgia Muscular Dystrophy

Integumentary

Shingles Eczema Cold Sores
Psoriasis Rosacea

Endocrine

Thyroid Dysfunction Diabetes (Type 1 or 2)

Hematologic/Lymphatic

Anemia High Cholesterol
Bleeding Problem

Allergic/Immunologic

Rheumatoid Arthritis Lupus

Eyes

Loss of Vision Distorted Vision
Loss of Side Vision Itching
Burning Redness
Floaters Flashes
Tearing/Watering Night Glare
Light Sensitivity Chronic Infection
Foreign Body Sensation

Do you use eye drops? Yes or No
If so, what type?_____

Do your experience episodes or periods of blurred vision? Yes or No

Do you have problems with your eyes when working on a computer, watching TV or reading? Yes or No