Welcome to Advanced Eyecare

First Name: ______________________________ Last Name:___________________________________ Date of Birth______ /________ / ________

Street: ____ Social Security Number __________________________

City / State: _____________________________________ Zip ________________

Home Phone (_____)____________________ Work Phone (_____)____________________ E-mail _____________________________________

Vision Insurance_____________________________________ Member's Name _____________________________________

How did you hear about us?____ ____

Date of last eye exam: ________ /__________ / _________ Reason for today's exam: ____

Are you taking ***ANY*** medications? ☐ Yes ☐ NO If YES, list the medication and what it is treating.

____

Are you allergic to ***ANY*** medications? ☐ Yes ☐ NO If YES, list which medication(s)____

Has there ever been ***ANY*** eye diseases diagnosed in your immediate family? ☐ Yes ☐ NO

If YES, what eye disease(s) and which relative(s)____

Many diseases of the body can have grave eye health consequences. For example, diabetes is one of the leading causes of blindness. Therefore, it is imperative that we acquire an in depth medical history. Please answer the following questions. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them. This information is also critical in the event we need to prescribe certain medications.

Since your last eye examination, have you suffered from or been treated for any of the following:

	No	Yes
Major dental disease		
Sinus problems		
Allergies		
Mitral valve prolapse		
Sarcoidosis		
Lupus		
Psoriasis		
Seizures		
Asthma		
Myasthenia Gravis		
Syphillis		
Shingles / herpes zoster		

	No	Yes
Diabetes		
High blood pressure		
Heart disease		
High cholesterol		
Ateriosclerosis		
Arthritis		
HIV		
Thyroid / Grave's disease		
Chronic obstructive pulmonary disease		
ANY cancer		

Since your last yearly eye health examination, have you suffered from ***ANY*** diseases not listed above? ☐ Yes ☐ NO

If yes, what disease(s)____

Date of last general examination (complete physical, not eye health examination ____________________

Occupation__________________________________

Special vision requirements (occupation/computer/hobbies/sports)____

Do you use a computer? ☐ Yes ☐ NO If YES, ______ hours / day ______ days / week.

Please return this to the front desk when completed. Thank you.