

East Hill Optometry

PATIENT'S INFORMATION

Date: ___/___/___

Last Name: _____ First: _____ MI: _____

Address: _____ City, State: _____

Zip: _____ SS# _____ - _____ - _____ Birth Date: ___/___/___ (M/F): ___

Home: _____ - _____ - _____ Cell: _____ - _____ - _____ Work: _____ - _____ - _____ X: _____

Employer: _____ Occupation: _____

Legal Guardian (U18): _____ Relation: _____

INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____

Insured Name: _____ D.O.B: ___/___/___

Relationship to Insured: _____

Personal Medical Information: Do you have any problems with any of these systems? If Yes, Please check box.

- | | | |
|---|---|---|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Nervous System | <input type="checkbox"/> Mental |
| <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Genitourinary | <input type="checkbox"/> Endocrine (Glands) |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Blood/Lymph |
| <input type="checkbox"/> Respiratory | <input type="checkbox"/> Skin | <input type="checkbox"/> Allergic/Immunologic |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Surgeries (what type & when) _____ | |

Are you in good health? Yes No **If no, what symptoms?** _____

Any allergic reactions to medications or other substances? Yes No

If yes, please list _____

Name of general physician _____

Do you smoke? Yes No **How much?** _____

Do you drink alcohol? Yes No **How Much?** _____

Do you take medications? Yes No **Please list names & how often** _____

Do you have family history of any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood pressure |
| <input type="checkbox"/> Macular Degen. | <input type="checkbox"/> Retinal Detachmt | <input type="checkbox"/> Cataracts |

Please explain any boxes you have checked _____

Do you have any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Wear Glasses |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Eye injuries | <input type="checkbox"/> Wear Contacts |

Any eye problems at this time? Please explain _____

Are you interested in laser vision corrections? Yes No

Signature _____ **Date** _____