EYE CARE CONSULTANTS

VISION SOURCE

WELCOME TO OUR OFFICE

PERSONAL INFORMATION

Name _____ Date _____ Sex □ Male □ Female
DOB_____ SSN_____ Email_____
Address:_____ City: _____ State: _____ Zip: _____
Home Phone #: _____ Work #: _____ Cell #: _____
Would you like to receive text messages to confirm upcoming appointments? □ Yes □ No
Are you: □ Minor □ Married □ Divorced □ Widowed □ Single □ Separated
Occupation _____ Employer Name _____
Name of Spouse _____ Spouse Employer _____
Emergency Contact: Name _____ Phone #_____
Referred to us by: _____
Primary Care Physician _____ Phone # _____
Primary Pharmacy _____ Phone#_____
Preferred Language: □ English □ Spanish □ Other Race _____ Ethnicity _____
Preferred Communication: □ Email □ Telephone □ Postal

MEDICAL HISTORY

♦ **Do you have allergies to medication**? □ No □ Yes
If yes, explain: _____
♦ **List any medication you take (including oral contraceptives, aspirin, over the counter medications, and home remedies – Please also include dosage):**

_____

_____

Do you currently smoke? □ No □ Yes **If not, have you before?** □ No □ Yes
Are you pregnant or nursing? □ No □ Yes **Last eye examination:**_____
Visual correction: □ **Glasses** How old is current pair? _____ □ **Contacts** How old is current pair? _____
Would you like new glasses today? □ No □ Yes **Would you like new contact lenses today?** □ No □ Yes
Are you interested in laser vision correction? □ No □ Yes **Do you use a computer regularly?** □ No □ Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions and the relationship of the family member to you:

□ Blindness _____ □ Cancer _____ _____ □ Cataract _____
□ Diabetes _____ □ Crossed Eyes _____ _____ □ Heart Disease_____
□ Glaucoma _____ □ High Blood Pressure _____ □ Keratoconus _____
□ Kidney Disease _____ □ Macular Degeneration _____ □ Lupus_____
□ Retinal Disease _____ □ Thyroid Disease _____ □ Other?_____

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection of fees, including reasonable attorney fees, and applicable court costs in addition to my outstanding balance. I understand that my insurance company has a contract with me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services tendered on my behalf or my dependents'. The policy of this office is that payment is expected at the time services are rendered.

_____ _____
PATIENT'S SIGNATURE **DATE**

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REVIEW OF SYSTEMS

Eyes:

Previous surgery □ YES □ NO
If Yes, explain_____
Contact lens □ YES □ NO
Rigid □ Soft □ Extended □ Other □
Are they comfortable □ YES □ NO
What brand_____
Pain □ YES □ NO
Double Vision □ YES □ NO
Glaucoma □ YES □ NO
Cataracts □ YES □ NO
Macular Degeneration □ YES □ NO
Dry Eyes □ YES □ NO
Flashes/Floaters □ YES □ NO
Injuries to the eye □ YES □ NO
Other?_____ □ YES □ NO

Ear, Nose and Throat:

Hard of hearing □ YES □ NO
Ringing in Ears □ YES □ NO
Vertigo □ YES □ NO

Cardiovascular:

Chest Pain □ YES □ NO
Dizziness □ YES □ NO
Fainting Spells □ YES □ NO
Shortness of Breath □ YES □ NO
Irregular Heart Beat □ YES □ NO
Difficulty Lying Flat □ YES □ NO

Constitutional:

Fatigue/Weakness □ YES □ NO
Fever □ YES □ NO
Weight Gain/Loss □ YES □ NO

Respiratory:

Cough □ YES □ NO
Congestion □ YES □ NO
Wheezing □ YES □ NO
Asthma □ YES □ NO

Gastriontestional:

Heartburn □ YES □ NO
Nausea/Vomiting □ YES □ NO
Jaundice/Hepatitis □ YES □ NO

Genito-Urinary:

Pain/Difficulty □ YES □ NO
Blood in Urine □ YES □ NO
History of Kidney Stones □ YES □ NO
History of STD's □ YES □ NO

Psychiatric:

Anxiety/Depression □ YES □ NO
Mood Swings □ YES □ NO
Difficulty Sleeping □ YES □ NO

Endocrine:

Incresased Thirst □ YES □ NO
Increased Hunger □ YES □ NO
Increased Urination □ YES □ NO
Inceased Sweating □ YES □ NO
Fingernail Changes □ YES □ NO

Blood/Lymphnodes:

Easy Bruising □ YES □ NO
Gums Bleed Easily □ YES □ NO
Prolonged Bleeding □ YES □ NO
Heavy Aspirin Use □ YES □ NO

MusculoSkeletal:

Stiffiness □ YES □ NO
Arthritis □ YES □ NO
Joint Pain/Swelling □ YES □ NO

Skin:

Rash/Sores □ YES □ NO
Lesions □ YES □ NO
Hives/Eczema □ YES □ NO

Neurological:

Seizures □ YES □ NO
Weakness/Paralysis □ YES □ NO
Numbness □ YES □ NO
Tremors □ YES □ NO

Immunologic:

Hives □ YES □ NO
Itching □ YES □ NO
Runny Nose □ YES □ NO
Sinus Pressure □ YES □ NO