

## PRIMARY EYECARE CENTER

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Name - Mr./Mrs./Ms./Dr. _____ Nickname/Preferred Name _____ Sex: M F Address _____ City, State, ZIP _____ Driver's License # _____ Phone (H) _____ (W) _____ Email _____ Medical Doctor (PCP) _____ Date of Last Visit with Medical Doctor _____ Reason for Last Visit with Medical Doctor _____ Last Eye Exam (if not here) _____ Last Eye Doctor (if not here) _____ Reason for today's visit _____	Today's Date _____ Birth Date _____ Referred by _____ SS# _____ Marital Status: Single/ Married /Widowed /Partner Special Needs _____ Race _____ Ethnicity: <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Hispanic/Latino Occupation or Grade _____ Employer or School _____ Mother's Maiden Name _____ Your State of Birth _____
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### Personal Medical History

Current Height \_\_\_\_\_ Current Weight \_\_\_\_\_

List **all medications** you take including oral contraceptives, aspirin, over-the-counter medications, vitamins and herbal supplements (**and dose if known**): \_\_\_\_\_

Do you have any **allergies** to medications?  No  Yes (list allergy and reaction) \_\_\_\_\_

List all major surgeries you have had with approximate date: \_\_\_\_\_

Are you pregnant / nursing? (If yes, circle which one) If pregnant, list due date: \_\_\_\_\_

**Diabetics:** Date of Diagnosis (month/year) \_\_\_\_\_ Last HbA1c (percentage) \_\_\_\_\_ / Date Taken \_\_\_\_\_

If you self-monitor blood sugar, list your last measurement / approximate date taken \_\_\_\_\_

Do you wear glasses?  No  Yes How old are your glasses? \_\_\_\_\_

Do you wear contact lenses?  No  Yes How old is this pair of lenses? \_\_\_\_\_

### Personal & Family Medical History

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

	Self	Relative	List Relatives Having the Condition
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strabismus (eye turn)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (specify type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Major Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Social History

(All information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you use tobacco products?  No  Yes type / amount / how long: \_\_\_\_\_  
If tobacco non-user:  Former smoker  Never Smoker  
Do you drink alcohol?  No  Yes type / amount / how long: \_\_\_\_\_  
Do you use illegal drugs?  No  Yes type / amount / how long: \_\_\_\_\_

Do you work on the computer?  No  Yes Approx hours per day on computer: \_\_\_\_\_

## Review of Systems

Please check the box if you currently have, or have had **significant** problems in the following areas:

### Eyes

- Blurred Vision
- Distorted Vision
- Halos
- Loss of Vision
- Loss of Side Vision
- Double Vision
- Dryness
- Discharge
- Redness
- Sandy or Gritty Feeling
- Itching
- Burning
- Excess Tearing / Watering
- Glare / Light Sensitivity
- Eye Pain
- Flashing Lights
- Floaters
- Chronic Infections
- Tired Eyes

### Constitution

- Fever
- Weight Loss / Gain

### Cardiovascular

- High Blood Pressure
- Cholesterol
- Angina
- Coronary Artery Disease
- Congestive Heart Failure
- Bypass Graft

### Ear, Nose, Mouth, Throat

- Sinus Congestion
- Chronic Sinusitis
- Runny Nose
- Post Nasal Drip
- Chronic Cough
- Dry Throat / Mouth
- Hearing Loss
- Ringing in Ears / Tinnitus
- Vertigo

### Respiratory

- Asthma
- Chronic Bronchitis
- COPD
- Emphysema
- Sarcoid
- Tuberculosis

### Stomach / Intestinal

- Diarrhea
- Constipation
- Gastric Reflux
- Crohn's Disease
- Ulcerative Colitis
- Hepatitis

### Genitourinary

- Genital / Kidney / Bladder

### Muscles / Bones / Joints

- Arthritis
- Rheumatoid Arthritis
- Osteoporosis

### Psychiatric

- Depression
- Anxiety

### Skin Conditions

- Eczema
- Psoriasis
- Dermatitis
- Skin Cancer

### Neurological

- Chronic Headaches
- Migraines
- Seizures
- Multiple Sclerosis
- Stroke
- TIA

### Endocrine

- Diabetes Type 1
- Diabetes Type 2
- Prediabetes
- Thyroid Disorder

### Lymphatic / Blood

- Anemia
- Systemic Lupus (SLE)
- Lyme Disease
- Other Blood disorder

### Allergies / Immunologic

- Allergies / Hayfever
- Autoimmune Disorder
- HIV / AIDS

### Cancer

- Type: \_\_\_\_\_

If you answered YES to any of the above or have a condition not listed above, please explain:

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I grant permission to Primary Eyecare Center to exchange information from my records with my insurance carrier and my other health care providers when appropriate.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



