WELCOME TO OUR OFFICE

EAGLE VISION
SUPERIOR FAMILY EYE CARE

Patient Information

Today's Date _____

Last _____
First _____MI _____
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___Email____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____
Date of Birth _____Age _____
Sex M F Primary Language _____
❑ Decline Race(s) _____
❑ Decline Ethnicity_____
What is the major purpose of this visit?

_____
Any problems with your current contact lenses or glasses?_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who 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 List
❑ Saw Sign/Building
❑ Newspaper
❑ Mailer
❑ Web Page
❑ Other

Insurance Information

Please note that insurance usually does NOT cover the Contact Lens Evaluation.

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer? ____Hours/week
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hours/week
❑..ski or snowboard?
❑..do detailed fine work?
❑..play music? Sing?
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..want information on Laser Vision Correction surgery?
❑..have children?
❑..have family members in need of eyecare?

Other Hobbies:_____

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Cataracts
❑ Macular Degeneration
❑ Glaucoma
❑ Diabetic Retinopathy
❑ Dry Eye
❑ Eye Infection
❑ Eye Allergy
❑ Floaters/Flashes of Light
❑ Iritis or Uveitis
❑ Retina defects
❑ Crossed Eye/Eye Turn
❑ Lazy Eye
❑ Eye Injury
❑ Other eye disorders_____

❑ Redness
❑ Burning
❑ Itching
❑ Tearing
❑ Discharge
❑ Blurred Vision
❑ Eyestrain
❑ Eye Pain
❑ Sunlight Sensitivity
❑ Headache
❑ Poor Night Vision
❑ Double Vision
❑ Total Loss of Vision

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____
Other Allergies?_____

Have you had any surgeries? ❑ Yes ❑ No
If so, list surgeries?_____
_____

Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Pregnant ❑ Yes ❑ No Nursing ❑ Yes ❑ No

Height _____ Weight_____

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes, Type_____	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

If you wear bifocals, do the lines or head tilting bother you? ❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Cancer	❑_____
Diabetes, Type____	❑_____
High Blood Pressure	❑_____
Thyroid Disorder	❑_____
Heart Disease	❑_____
Stroke	❑_____
Cataract	❑_____
Macular Degeneration	❑_____
Glaucoma	❑_____
Blindness	❑_____
Lazy Eye	❑_____
Retinal Problems	❑_____
Other	❑_____