EYE CARE SURGERY CENTER

PLEASE PRINT Today's Date _____

Patient Name_____
First Middle Last

Age _____ Birth Date _____ Gender *Male / Female* SS# _____

Marital Status: _____ E-Mail_____

Home Ph # _____ Cell Ph #_____ Work Ph #_____

Patient's Mailing address: _____
Street

_____
City State Zip

Place of employment_____ Employer Ph # _____

Do you have insurance? YES / NO **Insurance Company Name**: _____

Spouse's Name _____ Address if different _____

Spouse Cell # _____Spouse Work # _____

Will you be providing an advanced directive? **Yes No**

Emergency Contact: (Name of person ***other than spouse*** we should notify.)

Name: _____ Relationship: _____ Ph # _____

RESPONSIBLE PARTY INFORMATION (Please fill out if the patient is under the age of 18 OR if the **INSURANCE POLICY HOLDER** information is not the same as the patient.

Responsible Party _____ Relationship _____D.O.B._____

Address _____

Phone # _____ Cell Ph # _____ SS# _____

Were you referred by: □ Family or Friend □ Website □ Advertisement □ Other

□ Doctor If Doctor, please give name: _____

I hearby agree that this information is correct and current.

Patient's Signature X_____ Date:_____

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MEDICAL HISTORY

Name:_____ **Date:**_____

Date of last medical exam: _____ Last eye exam: _____

Pease note the reason for this visit: _____

_____

Medical History: Circle all that apply to you below.

Constitutional	**None** Fever	Weight Loss/Gain Fatigue	Other
Ear, Nose, Throat	**None** Sinus Problems	Hearing Problems	Other
Cardiovascular	**None** Heart Disease	High Blood Pressure High Cholesterol	Other
Respiratory	**None** Asthma	COPD Emphysema	Other
Gastrointestinal	**None** Stomach Ulcer	Liver Disease Crohn's Disease	Other
Musculoskeletal	**None** Joint Pain	Arthritis	Other
Skin	**None** Rosacea	Psoriasis Eczema	Other
Neurological	**None** Stroke	Headache	Other
Endocrine	**None** Diabetes	Thyroid Disease	Other
Hematological	**None** HIV/AIDS	Anemia Sickle Cell	Other
Allergic/Immunologic	**None** Seasonal Allergies	Sjogren's Rheumatoid	Other
Psychological	**None** Depression	Anxiety	Other
Other Medical Conditions			

Allergies: List any medication you are allergic to:

_____

_____

Medications: List all medications you are taking including eye drops. Include dosage if known.

_____

_____

_____

Have you ever used any of the following medications (circle those that apply).

Plaquenil_____Accutane_____Imitrex_____Cordarone_____Prostate Meds_____

Surgeries: List all surgeries including eye surgeries you have had with dates:

_____

_____

Do you use tobacco? _____ If so, how much and how often? _____

Do you drink alcohol? _____ If so, how much and how often? _____

Are you pregnant or nursing? *Yes Pregnant / Yes Nursing / No*

Family History (Please check if illness applies and their relation to you)

☐ Diabetes _____ ☐ Cataract_____
☐ Macular Degeneration _____ ☐ Cancer _____
☐ Blindness _____ ☐ Glaucoma_____
☐ Heart Disease _____ ☐ High Blood Pressure _____
☐ Retinal Detachment _____ ☐ Stroke _____
☐ Other _____

Pharmacy: What pharmacy do you use? Please list name, location and phone number if known.

_____

_____

Current Occupation: _____

Do you now, or have you ever worn contact lenses? *Yes now / In the past / Never*

If so, what type/brand and how many years did you wear them? _____

Do you wear glasses for Distant or Near vision? *Distance only / Near Only / Both*

Patient Signature: X_____ **Date:** _____