# Welcome to Image Eyecare

Patient's Name_____ Dr./Mr./Mrs. Ms./Miss (circle one) Today's Date _____/_____/_____
First Middle Initial Last

Address_____ City_____ State_____ Zip_____

E-Mail Address _____ Sex **M / F** Age_____ Date of Birth _____/_____/_____

Home Phone (_____)_____ Work Phone (_____)_____

Vision Insurance **Yes / No** Plan Name_____ Medical insurance **Yes / No** Plan Name _____

Occupation_____ Employed By_____

Do you use a computer? **Yes / No** How many hours a day? _____

What hobbies or sports do you participate in? _____

Have you been a patient in this office before? **Yes / No** How did you hear about us? _____

What is the main reason for today's visit? _____

## ***Eye and Health History***

Date of last Eye Exam_____/_____/_____ Date of last Physical Exam_____/_____/_____

Do you wear GLASSES? **Yes / No** CONTACT LENSES? **Yes / No** Are you interested in trying contact lenses? **Yes / No**

List any previous **EYE Injuries, Diseases, or Surgeries** _____ None_____

***Have you experienced any of the following?*** (Check all that apply. Check here if none apply___)

- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Loss of Side Vision
- ❑ Burning
- ❑ Glare/Light Sensitivity
- ❑ Floaters/Spots
- ❑ Tearing / Watering
- ❑ Dryness
- ❑ Eye Pain/Soreness
- ❑ Flashes of Light
- ❑ Mucous Discharge
- ❑ Itching

* Please explain_____

Do you use cigarettes / tobacco? **Yes / No** If female, are you pregnant or nursing? **Yes / No**

List ANY medications you currently take (including birth control or hormones): _____None_____

_____

List any medications you are allergic to_____ None_____

***Do you, or any of your immediate relatives, have any of the following?*** (Check all that apply. Check here if none apply__)

- ❑ Turned or lazy eye
- ❑ Glaucoma
- ❑ Retinal Problems
- ❑ High Blood Pressure
- ❑ Cataract
- ❑ Macular Degeneration
- ❑ Diabetes

* Please explain_____

***Do you currently, or have you ever had any problems in the following areas?*** (Check all that apply. Check here if none apply__)

- ❑ High Cholesterol
- ❑ Heart Disease
- ❑ Arthritis
- ❑ Cancer
- ❑ Kidney Disease
- ❑ Lupus
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Asthma / COPD
- ❑ Allergies
- ❑ Frequent Sinus / Ear Infections
- ❑ Autoimmune Disease / Lupus
- ❑ Blood Disorder / Anemia
- ❑ Headaches / Seizures
- ❑ HIV or other STD
- ❑ Kidney Urinary Tract Disease
- ❑ Anxiety / Depression
- ❑ Skin Condition
- ❑ Stomach / Bowel
- ❑ Other Medical Condition

* Please explain_____

***INFORMATION RELEASE CONSENT***

I authorize any holder of medical/optical information to release information about me to Image Eyecare and I authorize Image Eyecare to release medical/optical information about me to other healthcare providers, attorneys, or insurance companies.

*Note to Medicare Patients: Medicare will not pay for refractive services or other services deemed not medically necessary.*

***All patients are responsible for payment at time of service.***

Responsible Party_____

Signature_____Date_____/_____/____