Page Eye Center Patient Information Form

Name: _____ Today's Date: _____/_____/_____

P.O. Box _____ City _____ State _____ Physical Address: _____

Guardian (If Applicable): _____ Phone: _____

Birth Date: _____/____/_____ SS #: _____/_____/_____ Last Eye Exam: _____/_____/_____

Vision Insurance: _____ ID#:_____ Employer: _____

Medical Insurance: _____ ID#: _____ 2nd Med Ins: _____ ID#: _____

Marital Status: Married Single Widowed Minor Occupation: _____

Page Eye Center accepts all insurances benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by the insurance.** I authorize the use of my signature submissions.

_____
Signature of patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

Medical History *(Please Circle all that apply)*

Do you have any allergies to medication? Y/N If yes, explain:

_____
_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):_____
_____

Are you pregnant and/or nursing? Y/N

Who is your Primary Care Giver? _____ Date of last visit __/__/__

Family History

Please note any family history for the following conditions:

Diseases/Condition

Blindness Y/N Relation _____ Cataracts Y/N Relation _____
Crossed Eyes Y/N Relation _____ Glaucoma Y/N Relation _____
Macular Degeneration Y/N Relation _____ Retinal Detachment Y/N Relation _____
Arthritis Y/N Relation _____ Cancer Y/N Relation _____
Diabetes Y/N Relation _____ Heart Disease Y/N Relation _____
High Blood Pressure Y/N Relation _____ Kidney Disease Y/N Relation _____
Thyroid Disease Y/N Relation _____ Other: _____

PLEASE TURN THIS FORM OVER AND COMPLETE SIDE TWO

Social History

This information is kept strictly confidential. However you may discuss this portion with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes please describe:

_____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you do illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long:_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had problems in the following areas, please circle yes or no:

System		**Eye Continued:**		**Ears, Nose, Mouth, Throat:**	
Constitutional:	Y/N	Glare/Light Sensitivity	Y/N	Allergies/Hay Fever	Y/N
Fever,weight Loss/Gain	Y/N	Eye Pain or Soreness	Y/N	Sinus Congestion	Y/N
Integumentary (Skin)	Y/N	Sties or Chelation	Y/N	Runny Nose	Y/N
Neurological:		Flashers/Floaters in Vision	Y/N	Post Nasal Drip	Y/N
Headaches	Y/N	Tired Eyes	Y/N	Chronic Cough	Y/N
Migraines	Y/N	**Psychiatric:**	Y/N	**Bones/Joints/Muscles:**	
Seizure	Y/N	**Respiratory:**		Rheumatoid Arthritis	Y/N
Eyes:		Asthma	Y/N	Muscle Pain	Y/N
Loss of Vision	Y/N	Chronic Bronchitis	Y/N	Joint Pain	Y/N
Blurred Vision	Y/N	Emphysema	Y/N	**Lymphatic/Hematologic:**	
Distorted Vision	Y/N	**Vascular/Cardiovascular:**		Anemia	Y/N
Loss of Side Vision	Y/N	Diabetes	Y/N	Bleeding Problems	Y/N
Double Vision	Y/N	Heart pain	Y/N	Endocrine:	Y/N
Dryness	Y/N	High Blood Pressure	Y/N	Thyroid/Other Glands	Y/N
Mucous Discharge	Y/N	Vascular Disease	Y/N	**Allergic/Immunologic:**	
Redness	Y/N	**Gastrointestinal:**			
Sandy or Gritty Feeling	Y/N	Diarrhea	Y/N		
Itching	Y/N	Constipation	Y/N		
Burning	Y/N	**Genitourinary:**	Y/N		
Foreign Body Sensation	Y/N	Genitals/Kidney/Bladder	Y/N		
Excess Tearing/Watering	Y/N				

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

_____

_____

_____ _____

Doctor's Signature Date

Updates *(To be filled in a future visits)*

Has there been any change in your health since your last Eye Exam? Y/N

For what conditions?_____

Are you taking any new medications?_____

Patient's Signature_____

Doctor's Signature_____