St. Lucy's Eye Care Center, PC

Name: _____ Date: _____

Reason for Today's Visit: _____

_____

Date of Birth: _____ Date of last eye exam: _____

List of any medications you currently take (prescription& over-the-counter): _____

_____

Do you have new allergies to any medications, since your last visit? ☐YES ☐NO

If YES, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc) or injuries (concussion, etc.):

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____

FAMILY HISTORY

Relationship to Patient: M=Mother F=Father S=Sibling C=Children GP=Grandparent

Blindness	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP	High blood pressure	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP
Glaucoma	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP	Kidney disease	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP
Arthritis	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP	Lupus	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP
Cancer	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP	Stroke	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP
Diabetes	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP	Thyroid disease	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP
Heart disease	☐NO	YES,	☐M	☐F	☐S	☐C	☐GP	Other _____							

SOCIAL HISTORY: *Check One*

Do you drive?..... ☐YES ☐NO

Do you have visual difficulty when driving?..... ☐YES ☐NO

Do you have problems with night vision?..... ☐YES ☐NO

Have you ever tried to wear contact lenses?..... ☐YES ☐NO

Do you currently wear contact lenses?..... ☐YES ☐NO If YES, how long?_____

Do you currently wear glasses?..... ☐YES ☐NO If YES, how long have you had your current prescription?_____

Do you drink alcohol?..... ☐YES ☐NO If YES: ☐Occasional ☐1/day ☐2-3/day ☐4/day

DEMOGRAPHICS:

Gender: ☐M ☐F Occupation: _____ ☐Retired

Height: _____ Feet _____ Inches Weight: _____ Blood pressure: _____/_____

Smoker *(if 18 or older check one)*: ☐Former smoker ☐Never smoked ☐Unknown if ever smoked

☐Current everyday smoker (☐occasional ☐1/2 pack/day ☐1 pack/day ☐1+pack/day)

☐Current sometimes daily smoker (☐occasional ☐1/2 pack/day ☐1 pack/day ☐1+pack/day)

***As per "Meaningful Use" requirements, please fill out the information below.*
*Please let us know if you have any Concerns about filling out this part of the form.***

Preferred language: ☐English ☐Spanish ☐Other *(please specify)*_____

Race: ☐American Indian or Alaskan ☐Asian ☐Black or African American ☐Native Hawaiian or other Pacific ☐Islander ☐Other Race ☐White

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Please fill out reverse side →

Do you currently have any problems in the following areas?

EYES *If **YES**, please provide information*

Loss of vision	☐NO	☐YES	_____
Blurred vision	☐NO	☐YES	_____
Fluctuating vision	☐NO	☐YES	_____
Distorted vision (halos)	☐NO	☐YES	_____
Glare or light sensitivity	☐NO	☐YES	_____
Loss of side vision	☐NO	☐YES	_____
Double vision	☐NO	☐YES	_____
Dryness	☐NO	☐YES	_____
Mucous discharge	☐NO	☐YES	_____
Redness	☐NO	☐YES	_____
Sandy or gritty feeling	☐NO	☐YES	_____
Itching	☐NO	☐YES	_____
Burning	☐NO	☐YES	_____
Foreign body sensation	☐NO	☐YES	_____
Excess tearing or watering	☐NO	☐YES	_____
Eye pain or soreness	☐NO	☐YES	_____
Infection of eye or lid	☐NO	☐YES	_____
Tired eyes	☐NO	☐YES	_____
Crossed eyes, lazy eye	☐NO	☐YES	_____
Drooping eyelid	☐NO	☐YES	_____

GENERAL/CONSTITUTIONAL ☐NO ☐YES _____
(fever, weight, loss, other)

EARS, NOSE, THROAT ☐NO ☐YES _____
(stuffy nose, ear ache, cough, dry mouth, etc.)

CARDIOVASCULAR ☐NO ☐YES _____
(high BP, racing pulse, etc.)

RESPIRATORY ☐NO ☐YES _____
(congestion, wheezing, etc.)

GASTROINTESTINAL ☐NO ☐YES _____
(stomach upset, diarrhea, constipation, etc.)

GENITAL, KIDNEY, BLADDER ☐NO ☐YES _____
(painful urination, frequent urination, impotence, etc.)

MUSCLES, BONES, JOINTS ☐NO ☐YES _____
(joint pain, stiffness, swelling, cramps, etc.)

SKIN (pimples, warts, growths, rash, etc.) ☐NO ☐YES _____

NEUROLOGICAL (numbness, headache, etc.) ☐NO ☐YES _____

PSYCHIATRIC (anxiety, depression, insomnia) ☐NO ☐YES _____

ENDOCRINE (diabetes, hypothyroid, etc.) ☐NO ☐YES _____

BLOOD/LYMPH (choesterolorria, anemia, etc.) ☐NO ☐YES _____

ALLERGIC/IMMUNOLOGIC ☐NO ☐YES _____
(sneezing, swelling, redness, itching, hives, etc.)

Other Comments:

_____

_____

_____