Sergeant Bluff EyeCare

Patient Information

Today's Date_____

First/Last Name: _____MI_____ Date of Birth: ____/____/_____

Address: _____ SSN _____

City/State_____ Zip_____ Home Phone: _____

Email Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Employed/School Status: Full Time___ Part Time___ Not Employed___ Retired___ Active Military___

Male: ____ Female: ____ Marital Status: S M D W Preferred Language: _____

Race (**please circle**): Patient Decline Unknown American Indian
Asian African American Native Hawaiian/Pacific Islander
Other White

Ethnicity: Patient Declined Hispanic/Latino Not Hispanic/Latino

Spouse Information

Spouse's Name _____ Date Of Birth: ____/____/____

Address (If different as above): _____

City/State/Zip: _____ SSN: _____

Employer: _____ Cell Phone: _____

Parent Information (If a Minor)

Father's Name: _____ Date Of Birth: ___/___/____

Address (If different from patient): _____

City/State/Zip: _____ SSN: _____

Employer: _____ Cell Phone: _____

Mother's Name: _____ Date Of Birth: ____/____/____

Address (If different from patient): _____

City/State/Zip: _____ SSN: _____

Employer: _____ Cell Phone: _____

Ocular History **Please circle all that applies**

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, what type? Hard Soft Toric Multifocal Monovision

Do you wear them: Full time Part Time How frequently do you replace them? _____

Have you had refractive Surgery? _____ If yes, Date _____

Are you having any visual difficulties? _____ If yes, please explain _____

_____

Are you currently experiencing any of the following problems with your eyes? **Circle all that apply**

Blurred Vision	Flashes/Floaters	Redness
Loss of Vision	Halos/Glare/light sensitivity	Excess tearing/watering
Loss of side Vision	Dryness	Eye pain/soreness
Distorted Vision	Sandy or gritty feeling	Mucous discharge
Double Vision	Burning	Inflammation of eyelids
Tired Eyes	Itching	Styes or Chalazion

Have you been diagnosed with any of the following ocular problems? **Circle all that apply**

Cataracts	Glaucoma	Retinal Detachment/ Disease
Crossed Eyes	Lazy Eye/Amblyopia	Dry Eye
Eye Injury	Macular Degeneration	Other _____

Medical History List any medications you are currently taking (including over the counter medications):

_____

_____

Are you allergic to any medications? No Yes If yes, which ones: _____

List all major surgeries and/or hospitalization _____

Review of Systems Please Circle all that apply

Allergies	Heart Disease	Thyroid Disease	Ear/Nose/Throat Disease
Headaches/Migraines	High Blood Pressure	Rheumatoid Arthritis	Respiratory/Lung Disease
Dizziness	High Cholesterol	Muscle/Joint Pain	Digestive/GI Disease
Seizures	Diabetes	Cancer	

Family History Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following

	Relation to You		Relation to You
Glaucoma	_____	Diabetes	_____
Macular Degeneration	_____	Cancer	_____
Retinal Detachment	_____	Heart Disease	_____
High Blood Pressure	_____	Blindness	_____

**May we release any medical information, including prescriptions, to family members? If so please list:

_____

Signature: _____ **Date:** ____/____/____