|  |
| --- |
| **Pulmonary*** Asthma
* Emphysema
* Bronchitis
* Allergies
* Tuberculosis
* Pneumonia
* Sarcoidosis
* Lung Disease

**Endocrine*** Diabetes
* Thyroid Disease

**Gastrointestinal*** Bowel Problems
* Digestive Problems
* Ulcer Disease
* Liver Disease
* Gallbladder Disease
* Pancreatic Disease

**Skin*** Melanoma
* Shingles
* Herpes
* Fever Blisters
* Rash

**Constitutional/other*** Fever
* Weight Change
* Sleep Apnea
* COPD
* Lupus
* MS
* Blood Clotting
* Short Breath
* Breathing problems
* MVP
* GERD

**Mental Status****Genitourinary*** Kidney Problems
* Bladder Problems
* Prostate Problems

**Cardiovascular*** Heart Disease
* Enlarged Heart
* Irregular Heart Beat
* Shortness of Breath
* High Blood Pressure

**Hematology*** Anemia
* HIV +
* Hepatitis \_\_\_\_\_
* Sickle Cell/ Trait
* Cancer/Melanoma
* Attended Auburn

**Musculoskeletal*** Arthritis
* Back/Neck Problems
* Depression
* Anxiety
* Dementia
* Psychosis

Other:**Neurology*** Stroke
* Seizures
* Paralysis
* Dizziness
* Double Vision

**Head*** Hearing Loss
* Sinus Problems
* Headaches/Migraines
* Dry Mouth
* Seasonal Allergies
* Stress/Tension
 |

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
|  Welcome to steel city eye care! |  |  |
| DOB: AGe:  | Full Name:  | SSN: |
| CELL #: | Street: Zip: | Employer: |
| WORK #: | EMAIL: | Occupation: |
| medical insurance company: | Cardholder name:Cardholder DOB: | Hobbies: |
| Vision insurance company: | Cardholder name:Cardholder last 4: | Date last eye exam:Location: |
| Please check the following:* I HAVE READ AND AGREE TO THE OFFICE AND HIPPA POLICY TERMS AND CONDITIONS
 | **OBJECTIONS to HIPPA POLICY:*** DO NOT FILE HEALTH AND/OR VISION INSURANCE
* DO NOT OBTAIN MEDICINE LIST FROM PHARMACY
* DO NOT COMMUNICATE WITH MY PHYSICIAN
 | * DO NOT TEXT
* DO NOT EMAIL
* DO NOT LEAVE A MESSAGE
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| What problems are you having  with your EYES? | Yes(√) | No(√) (√) | Reason for Visit/other concerns | Date of Last physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Past surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Females: Pregnant or nursing? Yes No |
| Blurred Vison-Far, Near, Middle |  |  |  |
|  Sudden Vison Loss |  |  |  | Contact Brand:* Dispose daily
* Dispose monthly
* Dispose weekly
* Gas permeable
 |
|  “Tired Eyes”/Eye Strain |  |  |  |
|  Dry Eyes |  |  |  |
|  Tearing, Redness, Watering |  |  |  |
|  Discharge, Crusting |  |  |  |
|  Eyelid Swelling |  |  |  | Remove: Nightly/weekly/monthlyAge of current pair\_\_\_\_\_\_\_\_\_\_\_\_\_\_Comfortable Yes No Solution Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you air dry your case daily?* Yes
* No
 |
|  Amblyopia/Patching |  |  |  |
|  History of Eye Injury/Surgery |  |  |  |
|  History of Seeing Floaters |  |  |  |
|  Glaucoma (you or family) |  |  |  |
|  Soreness/Light Sensitivity |  |  |  |
|  Macular Degeneration (you or family) |  |  |  |
|  Retinal Detachment (you or family) |  |  |  |
|  Computer Use |  |  | # hours/day: \_\_\_\_ |
|  Wear Glasses |  |  | Single Vision-Distance or Near Vision/Bifocals/ Trifocals/Progressives |
| Please list any drug allergies: |  |
| Please list any current medicines: |  |
| Today I am Interested in: Glasses Sunglasses Contact Lenses-Clear/Colored  |
| * **Please check here if none of the following apply:**
 |