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| **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 | |

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| 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/monthly  Age 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:** | | | | |