NEWBERRY VISION CENTER

Patient Information Form

Thank you for choosing us as your eye-care provider. In order to serve you properly, our staff needs the following information. This form is strictly confidential.

(Mr. Mrs. Ms. Miss) Today's Date: _____/_____/_____ Date of Last Eye Exam: _____/_____/_____

Patient's First Name: ______________________ MI: _____ Last Name: ______________________

Mailing Address: ______________________ City: ____________ State: _____ ZIP: __________

SSN: ______-_____-______ DOB: _____/_____/_____ Cell Phone: ______________

Marital Status: Married Single Divorced Widowed Evening Phone:______________

Name of Parent / Spouse (if applicable): ______________ Email Address:______________________

Patient / Parent Employer: ______________________ Occupation: ______________________

Insurance Information

VISION INSURANCE

Name of Insured: __________________ Relationship to Patient: __________ Insured's DOB: ___/___/___

Insurance Company: __________________ Member ID/SSN: ______________ Group #: ______________

HEALTH INSURANCE

Name of Insured: __________________ Relationship to Patient: ____________ Insured's DOB: ___/___/___

Insurance Company: __________________ Member ID/SSN: ______________ Group #: ______________

How did you find out about us?

- ❐ Yellow Pages
- ❐ Sign
- ❐ Web-site
- ❐ Patient Referral (Name__________)
- ❐ Insurance
- ❐ Other __________

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) of the following:

Condition				(relation to you)
Blindness	❐ Yes	❐ No	❐ ?	____________
Cataract	❐ Yes	❐ No	❐ ?	____________
Crossed Eyes	❐ Yes	❐ No	❐ ?	____________
Glaucoma	❐ Yes	❐ No	❐ ?	____________
Macular Degeneration	❐ Yes	❐ No	❐ ?	____________
Retinal Detachment/Disease	❐ Yes	❐ No	❐ ?	____________
Arthritis	❐ Yes	❐ No	❐ ?	____________
Cancer	❐ Yes	❐ No	❐ ?	____________
Diabetes	❐ Yes	❐ No	❐ ?	____________
Heart Disease	❐ Yes	❐ No	❐ ?	____________
High Blood Pressure	❐ Yes	❐ No	❐ ?	____________
Kidney Disease	❐ Yes	❐ No	❐ ?	____________
Lupus	❐ Yes	❐ No	❐ ?	____________
Thyroid Disease	❐ Yes	❐ No	❐ ?	____________
Other	❐ Yes	List: ____________		

Medical History

Medical Doctor's Name: __________________ Phone #: ______________ Date of Last Medical Exam: __________

Do you have any allergies to medications? ❐ Yes ❐ No If yes, please explain: ______________________

____

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

____

____

List all major injuries, surgeries, and/or hospitalizations you have had: ______________________

____

Circle any of the following **you** have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injury: ______________________

Are you pregnant and/or nursing? ❐ Yes ❐ No

Do you wear glasses? ❐ Yes ❐ No If yes, how old is your current pair of lenses? ______________

Do you wear contact lenses? ❐ Yes ❐ No If yes, how old is your current pair of lenses? ______________

Type of contact lenses worn: ❐ rigid ❐ soft ❐ extended wear ❐ other Are they comfortable? ❐ Yes ❐ No

Newberry Vision Center

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ☐ Yes, I would prefer to discuss my Social History directly with my doctor.

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 drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? ______________________

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long? ______________________

Have you ever been exposed to or infected with: ☐ No ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently have any problems in the following areas?

SYSTEM	YES	NO	?
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Integumentary			
Skin	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Diabetes	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐

	YES	NO	?
Ear,Nose,Mouth,Throat			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
High Cholesterol	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Allergic/Immunologic	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list related medications:

____

____

Signature of Reviewing Physician: ______________________ Date: ____________

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