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.

(Dr. 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:

				(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

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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: ______________

Signature of Reviewing Physician: ______________________ Date: ______________

Signature of Reviewing Physician: ______________________ Date: ______________

Signature of Reviewing Physician: ______________________ Date: ______________