Eagle Point Eye Care, PC

Patient Information & Health History

Patient Name: ____________________

Today's Date: ____________ Date of Birth: ____________ Gender: ________

Mailing Address: ____________________

Occupation: ____________________ SSN (for insurance billing): ____________

Telephone: ____________________ Email: ____________________

Insurance Information

PRIMARY INSURANCE

Insurance Name: ____________

Primary Member Name: ____________

Primary Member DOB: ____________

Primary Member SSN: ____________

SECONDARY INSURANCE

Insurance Name: ____________

Primary Member Name: ____________

Primary Member DOB: ____________

Primary Member SSN: ____________

Medical History

Date of Last Eye Exam: ____________ Date of Last Medical Exam: ____________

Current Medications: ____________________

Allergies to Medications: ____________________

Major Surgeries/Injuries: ____________________ If Female, Pregnant/Nursing: Y / N

PERSONAL EYE HISTORY

Allergies Y / N Dry Eye Y / N Glaucoma Y / N

Cataract Y / N Diabetes Y / N Eye Trauma Y / N

Macular Degeneration Y / N Other: ____________________

Glasses Wearer Y / N Soft Contact Lens Wearer Y / N Hard Contact Lens Wearer Y / N

Medical History Continued

PERSONAL HEALTH HISTORY

Please indicate whether you have any significant problems in the following areas:

Seasonal Allergies	Y / N	Hypertension	Y / N	Weight Changes	Y / N
Motion Sickness	Y / N	Acid Reflux	Y / N	High Cholesterol	Y / N
Diabetes	Y / N	Bowel Disease	Y / N	Kidney Disease	Y / N
Headache	Y / N	Anemia	Y / N	AIDS/HIV	Y / N
Dermatitis	Y / N	Rosacea	Y / N	Asthma	Y / N
COPD	Y / N	Cancer	Y / N	Other: ____________________	

FAMILY HEALTH HISTORY

*Please indicate whether the following have affected **family members** (parents, grandparents, siblings, and/or children):*

Glaucoma	Y / N	Relationship: ______________________________
Macular Degeneration	Y / N	Relationship: ______________________________
Retinal Detachment	Y / N	Relationship: ______________________________
Cancer	Y / N	Relationship: ______________________________
Heart Disease	Y / N	Relationship: ______________________________
High Blood Pressure	Y / N	Relationship: ______________________________
Thyroid Disease	Y / N	Relationship: ______________________________
Other ________________________		Relationship: ______________________________

SOCIAL HISTORY

This information is kept strictly confidential. You may also choose to leave blank and discuss with the doctor directly.

Tobacco Use Y / N If yes, type/amount/how long: ______________________________

Alcohol Use Y / N Illegal Drug Use Y / N

Have you ever been exposed to/infected with (circle if yes): HIV Syphilis Chlamydia Hepatitis

Do you drive? Y / N If yes, do you have visual difficulty when driving? Y / N

Doctor's Signature: ______________________________ Date: ____________________