Eagle Point Eye Care, PC

Patient Information & Health History

Patient Name: ______________________________ Today's Date: ______________

Last Four Digits of SSN (for billing): ________ Date of Birth: ______________ Gender: ____

Mailing Address: ____

City: ________________________ State: __________ Zip: __________

Telephone: ____________________ Occupation: ____________________

Insurance Information

PRIMARY INSURANCE

Insurance Name: ____________________

Primary Member Name: ________________

Primary Member DOB: ________________

Primary Member SSN (Last 4 Digits): ________

SECONDARY INSURANCE

Insurance Name: ____________________

Primary Member Name: ________________

Primary Member DOB: ________________

Primary Member SSN (Last 4 Digits): ________

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: ______________________________

Do You Wear: Glasses? ☐ Y ☐ N Soft Contacts? ☐ Y ☐ N Hard Contacts? ☐ 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 Alcohol Use ☐ Y ☐ N Drug Use ☐ Y ☐ N

If yes, type/amount/how long: ____

Have you ever been exposed to/infected with (check 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: ____________