UPTOWN EYE CARE PATIENT INFORMATION FORMS

Last name: **First:** **Middle Initial:** **Reason for today's visit:**

Birth Date: / / **Age:** **Email Address:** **Height:** **Weight:** **(Required by some insurance providers)** **Sex:** ❑ M ❑ F

Street address: **City** **State** **Zipcode**

Home Phone #: ( ) **Cell Phone #:** ( ) **Work Phone:** ( ) Where may we contact you? (check all that apply) ❑ Call (Home/Cell/Work) ❑ Text ❑ Email

Occupation: **Employer or School:**

Race/Ethnicity:

Emergency Contact (Name, Relationship, Phone):

Primary Care Physician: **Preferred Pharmacy:**

How did you find our office? ❑ **Prior patient** ❑ **Google** ❑**Facebook** ❑ **Advertisement** ❑ **Special Events** ❑**Word of Mouth**

If word of mouth, who may we thank for referring you? **Name:** _____

HEALTH HISTORY

☐ Cancer
☐ Fatigue Syndrome
☐ Hearing Loss
☐ Sinusitis
☐ Multiple Sclerosis
☐ Tumor
☐ Migraine
☐ Epilepsy
☐ Stroke
☐ Depression
☐ Anxiety Disorder
☐ Attention Deficit
☐ Bipolar Disorder
☐ Congestive Heart Failure
☐ Heart Disease
☐ High Blood Pressure
☐ Vascular Disease
☐ Bronchitis
☐ Chronic Obstruction
☐ Emphysema
☐ Sleep Apnea
☐ Asthma
☐ Acid Reflux
☐ Colitis
☐ Celiac Disease
☐ Crohns Disease
☐ Kidney Disease
☐ Rheumatoid Arthritis
☐ Muscular Dystrophy
☐ Osteoporosis
☐ Fibromyalgia
☐ Arthritis
☐ Thyroid
☐ High Cholesterol
☐ Other _____

Do you have Diabetes?
☐ Yes ☐ No

If yes, what treatments are you on?
☐ Oral Medications
☐ Insulin
☐ Diet Control

Additional Questions for Patients with Diabetes
What year were you diagnosed? _____
What type do you have: Type I or Type II? _____
Do you feel it is stable or unstable? _____
What was your last A1c (3 month average)? _____
What is your average fasting blood glucose level (morning reading)? _____
Is another doctor (such as endocrinologist) besides your primary care physician involved in managing your diabetes? If so, who? _____

Are you pregnant or nursing?
☐ Yes (Circle above) ☐ No

Do you use any tobacco products?
☐ Yes ☐ No Type:_____
For How long: _____

Please list any allergies (include food, environmental and drug allergies)

OCULAR HISTORY: DO YOU HAVE ANY OF THE FOLLOWING?

☐ Flashes of Light
☐ Strabismus (Crossed Eyes)
☐ Eye Surgery_____
☐ Cataract
☐ Glare Problems
☐ Macular Degeneration
☐ Patching
☐ Retinal Detachment/Hole
☐ Dry Eyes
☐ Inflammatory Disorder
☐ Amblyopia (Lazy eye)
☐ Other _____
☐ Glaucoma
☐ Glaucoma Suspect
☐ Eye Injury

FAMILY MEDICAL AND OCULAR HISTORY (Parents, Siblings, Kids-Please list relative next to condition)

☐ Cancer ☐ High Blood Pressure ☐ Retinal Detachment ☐ Strabismus(Crossed Eye)

☐ Diabetes ☐ Thyroid Problems ☐ Retinal Hole ☐ Amblyopia (Lazy Eye)

☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Other _____

MEDICATIONS

Please list any current medications including prescriptions, over the counter medications, vitamins, topical creams and eye drops **or provide a list for us to copy**. Include dosages if known. Many medications have ocular side effects and is important for us to know what you are using.

CONTACT LENS HISTORY

Do you currently wear contact lenses? ☐ Yes ☐ No

Are you interested in a Contact Lenses?☐ Yes ☐ No

New Patients: What brand do you wear?

_____

How often do you replace your lenses? _____

How often do you sleep in your lenses? _____

Are you having dryness and discomfort with your lenses? Yes No

What contact lens solution do you use? _____

Do you use any rewetting drops? _____ _____

Are you interested in upgrading your lenses to a more comfortable or healthier newer technology lens? _____