Welcome to East Windsor Eye Care

Patient Information

Today's Date: _____/____/

Last

First_____MI

Street_____ City

State_____Zip

Home Phone

Cell/Work Phone

Email Address

Date of Birth_____Age_____ Sex M F

Social Security #

Employer

Any specific issues you wish to address with the Doctor?

If you currently wear glasses:

How old is your current prescription?

Are you interested in:

π Glasses?
π Contact Lenses?
π Vision Corrective Surgery?

Do you…..(check box if your answer is yes)

π Work at a computer more than 3 hours a day?
π spend time outdoors? How much?____ hrs./day
π require safety glasses for work or sports?

Date of last Eye Exam:

Insurance Information

Vision Insurance

Subscriber Name
Member ID#
Subscriber Birth Date___/__/____
Subscriber Employer_____
Relationship to Patient_____

Medical Insurance

Subscriber Name
Subscriber ID#:
Group #
Subscriber Birth Date___/__/_____ Relationship to Patient

For insurance purposes are you:
π single π married π other

Eye Health History

Please check off if you are currently experiencing any of the following:

πBlurry Vision
π Burning
π Cataracts
π Corneal Abrasions
π Crossed Eye/Turn
π Double Vision
π Eye Infections
π Eye Injury
π Flashes of light
π Floaters/Spots
π Glaucoma
π Grittiness
π Headaches
π Iritis/Uveitis
π Eye Pain
π Itchiness
π Color Blindness
πMacular Degeneration
π Dryness
π Retinal Detachment
π Sunlight Sensitivity
π Tearing
πTrouble seeing at night
πOther Eye Disorders

Have you had any major eye infections/disorders?

Have you ever had any eye surgery or injuries?

Patient Medical History

Name of Family Physician

Town_____ Date of last check up

Current Medications (Rx or OTC)
(List name of medications including eye drops, vitamins, and birth control pills)

_____

Allergies to medications? π Y π N
If yes, which?

Have you had any surgeries in the last five years?
π Y πN Please List:

_____

Are you currently pregnant or nursing π Y π N

Do you use cigarettes/tobacco, alcohol, or other substances? πY πN

Have you ever been diagnosed or treated for the following health problems?

πSeasonal Allergies πArthritis
πHigh Blood Pressure πMuscular Dystrophy
πHigh Cholesterol πMultiple Sclerosis
πHeart Disease πChronic Headaches
πFatigue/Weight Loss πSeizures
πDiabetes πDepression
πCrohn's Disease πADD
πThyroid Disorder πNeurologic Disorder
πAcid Reflux πAsthma
π Digestive Disorders πCOPD
πSTDs/STIs πCystic Fibrosis
πKidney/Bladder πLung Disorders
πBlood/Lymph πSarcoidosis
πCancer _____
(type and location)

For contact lens wearers only:

Do you currently wear contacts? πY πN
What Brand?_____ Rx in lenses: **Right**_____ **Left**_____

How often do you dispose of your lenses?

Do your contacts feel dry? πY πN

Are you interested in Dailies? πY πN

How often do you sleep in your lenses?

Family Medical/Eye History

Please check any that apply to your family and state who the member is:

Blindness π
Cataracts π
Corneal Problems π
Lazy Eye π
Glaucoma π
Macular Degeneration π
Retinal Problems π
Diabetes π
Heart Disease π
High Cholesterol π