mt. pleasant EYE CARE CENTER, P.A.
BRIAN K. NICHOLS, O.D.
903-572-1991
www.mpeyecare.com

LAST NAME _____ FIRST NAME _____ MI_____

PREFERRED NAME_____ DATE OF BIRTH M:_____ D:_____ Y: _____

ADDRESS_____

City_____STATE_____ZIP_____

PHONE(HOME)_____ WORK_____ CELL_____

EMAIL_____(FOR OFFICE USE ONLY) GENDER M / F

SS # _____-_____-_____ OCCUPATION _____

EMPLOYER_____

EMERGENCY CONTACT NAME:_____ PHONE _____

PARENT OR SPOUSE NAME: _____

PERSON RESPONSIBLE FOR PAYMENT:_____

METHOD OF PAYMENT: INSURANCE ☐ MEDICARE ☐ CASH ☐ CHECK ☐ CARD ☐

DO WE SEE ANY OF YOUR FAMILY MEMBERS: YES ☐ NO ☐

HOW DID YOU HEAR ABOUT OUR OFFICE? INSURANCE ☐ WEBSITE ☐ FAMILY/FRIEND☐ OTHER☐

PREFERRED LANGUAGE: ENGLISH ☐ SPANISH ☐

RACE: AFRICAN AMERICAN/BLACK ☐ ASIAN ☐ CAUCASIAN/WHITE ☐ HISPANIC/LATINO ☐ MULTI ☐

ETHNICITY: HISPANIC/LATINO ☐ NOT HISPANIC/LATINO ☐ OTHER ☐

----------MEDICAL INFORMATION----------

WHAT IS YOUR GENERAL HEALTH? _____

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS? (CHECK ALL THAT APPLY)

| System | Yes | No | System | Yes | No | System | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Eyes | O | O | Gastrointestinal | O | O | Nervous | O | O |
| Ears/Nose/Throat | O | O | Mental | O | O | Cardiovascular | O | O |
| Genitourinary | O | O | Endocrine (Glands) | O | O | Blood/Lymph | O | O |
| Musculoskeletal | O | O | Respiratory | O | O | Integumentary (Skin) | O | O |
| Allergic/Immunologic | O | O | Diabetes | O | O | Type_____ Date Diagnosed: | | |

IF YOU ANSWERED YES TO ANY OF THOSE QUESTIONS PLEASE EXPLAIN:

_____

_____

***PLEASE ANSWER ALL THAT APPLY:***

CURRENT MEDICATIONS:_____

_____

MEDICATION ALLERGY: YES ☐ NO ☐ WHAT MEDICATION _____

WHAT HAPPENS WHEN YOU TAKE THE MEDICATION_____

LIST ANY SURGERIES YOU'VE HAD _____

_____

DO YOU USE CIGARETTES/TOBACCO? YES ☐ NO ☐ DO YOU DRINK ALCOHOL? YES ☐ NO ☐

HISTORY OF SEXUAL TRANSMITTED DISEASES? YES ☐ NO ☐

NAME OF PRIMARY CARE PHYSICIAN_____DATE OF LAST VISIT_____

----------FAMILY HISTORY----------

| History of: | Yes | No | Who/Relationship |
|---|---|---|---|
| High Blood Pressure | O | O | |
| Diabetes | O | O | |
| Macular Degeneration | O | O | |
| Retinal Detachment | O | O | |
| Glaucoma | O | O | |
| Other Eye Conditions | O | O | |
| If yes, what kind | | | |

----------PERSONAL EYE INFORMATION----------

DATE OF LAST EYE EXAM_____ DILATED____YES ___NO

ANY EYE SURGERIES NO ☐ YES ☐ IF YES WHAT KIND?___ _____

ANY EYE INJURIES NO ☐ YES ☐ IF YES, WHAT KIND?_____

| History: | Yes | No | History: | Yes | No | History: | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Glaucoma | O | O | Cataracts | O | O | Dry Eyes | O | O |
| Blurry Vision | O | O | Macular Degeneration | O | O | Other Eye Problems | O | O |

If Yes to other eye problems what type?_____

DO YOU WEAR GLASSES? YES ☐ NO ☐

IF YES, WHAT KIND? SINGLE ☐ BIFOCAL ☐ TRIFOCAL ☐ PROGRESSIVE ☐

DO YOU WEAR CONTACT LENSES? YES ☐ NO☐ WHAT BRAND/KIND?_____

PATIENT SIGNATURE_____ Date_____

PARENT SIGNATURE(if patient is a minor)_____ Date_____