mt. pleasant EYE CARE CENTER, P.A. *FOR PEOPLE WHO SEE THE DIFFERENCE*

Date: _____

LIST FULL LEGAL NAME ONLY

LAST NAME:_____ FIRST NAME:_____ MIDDLE INTITIAL:_____

NICKNAME:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: *HOME*_____ *WORK*_____ *CELL*_____

EMAIL:_____ (*FOR OFFICE/PATIENT COMMUNICATION ONLY*)

SOCIAL SECURITY NUMBER:_____-_____-_____ DATE OF BIRTH: (M)_____(D)_____(Y)_____ GENDER: M / F

OCCUPATION:_____ EMPLOYER:_____

EMERGENCY CONTACT / TELEPHONE NUMBER:_____ _____#_____

NAME OF PARENT OR SPOUSE:_____

PERSON RESPONSIBLE FOR PAYMENT:_____

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

HAVE WE SEEN ANY OTHER FAMILY MEMBERS: ☐ YES ☐ N0

IF YES, WHOM:_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ INSURANCE ☐ MAIL OUTS ☐ NEWSPAPER ☐ TELEPHONE BOOK ☐ FAMILY/FRIEND ☐ LOCATION ☐ WEB

PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH

RACE: ☐ AFRICAN AMERICAN / BLACK ☐ ASIAN ☐ CAUCASION / WHITE ☐ HISPANIC / LATINO ☐ MULTIRACIAL

ETHNICITY: ☐ HISPANIC / LATINO ☐ NOT HISPANIC / LATINO

- MEDICAL INFORMATION -

WHAT IS YOUR GENERAL HEALTH?_____

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

EYES…….. ☐ YES ☐ NO

GASTROINTESTINAL…. ☐ YES ☐ NO **NERVOUS** …….. . ☐ YES ☐ NO **MENTAL**……..... ☐ YES ☐ NO

EAR / NOSE / THROAT.. ☐ YES ☐ NO **GENITOURINARY**…….. ☐ YES ☐ NO **ENDOCRINE (GLANDS)**…… . ☐ YES ☐ NO

CARDIOVASCULAR……. ☐ YES ☐ NO **MUSCULOSKELETAL**……. ☐ YES ☐ NO **BLOOD / LYMPH**…….. ☐ YES ☐ NO

RESPIRATORY …….. ☐ YES ☐ NO **INTEGUMENTARY (SKIN)**.. ☐ YES ☐ NO **ALLERGIC / IMMUNOLOGIC** …... ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:_____

_____

- MEDICAL INFORMATION CONTINUED -

PLEASE ANSWER ALL THAT APPLY:

DIABETES: ☐ YES ☐ NO TYPE:_____ DATE OF DIAGNOSIS:_____

MEDICATION ALLERGY: ☐ YES ☐ NO WHAT MEDICATION? _____ WHAT HAPPENS?_____

OTHER HELP PROBLEMS:_____

CURRENT MEDICATIONS:_____

HAVE YOU EVER HAD ANY OPERATIONS? ☐ YES ☐ NO KIND?_____

DO YOU USE CIGARETTES / TOBACCO?_____ ALCOHOL? _____ OTHER SUBSTANCES?_____

HISTORY OF STD'S?_____

NAME OF FAMILY DOCTOR?_____ DATE OF LAST VISIT?_____

- FAMILY HISTORY -

HIGH BLOOD PRESSURE? ☐ YES ☐ NO RELATION:_____

DIABETES? ☐ YES ☐ NO RELATION:_____

MACULAR DEGENERATION? ☐ YES ☐ NO RELATION:_____

RETINAL DETACHMENT? ☐ YES ☐ NO RELATION:_____

GLAUCOMA? ☐ YES ☐ NO RELATION:_____

OTHERE EYE CONDITION? ☐ YES ☐ NO RELATION:_____

IF YES, WHAT KIND?_____

- PERSONAL EYE INFORMATION -

DATE OF LAST EXAM_____ DILATED?_____

HAVE YOU HAD AN EYE OPERATIONS? ☐ YES ☐ NO

IF YES, TYPE:_____

HAVE YOU HAD AN EYE INJURY? ☐ YES ☐ NO

IF YES, KIND:_____

DO YOU HAVE GLAUCOMA? ☐ YES ☐ NO DO YOU HAVE DRY EYES? ☐ YES ☐ NO

DO YOU HAVE CATARACTS? ☐ YES ☐ NO DO YOU HAVE BLURRED VISION? ☐ YES ☐ NO

DO YOU HAVE OTHER EYE PROBLEMS? ☐ YES ☐ NO DO YOU HAVE MACULAR DEGENERATION? ☐ YES ☐ NO

IF YES, KIND?_____

DO YOU WEAR GLASSES? ☐ YES ☐ NO DO YOU WEAR CONTACT LENSES? ☐ YES ☐ NO

IF YES, WHAT TYPE?_____

ADDITIONAL INFORMATION?_____

PATIENT'S SIGNATURE _____ DOCTOR'S INITIALS _____

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