Welcome to COMPLETE VISION CARE

Name:_____ Age:_____ Today's Date:_____

Address:_____ Birth date: _____

_____ SSN:_____

Employer (if applicable):_____

Occupation (if student, what grade?) _____

1° Medical Insurance (Company / Group # / Member ID) _____

2° Medical Insurance (Company / Group # / Member ID), if applicable _____

Vision Plan (Company / Member ID), if applicable _____

Cell:_____ Work:_____ Home:_____

Email Address:_____

*** Do you live in a skilled nursing facility? Yes No

Spouse/Parent Name:_____ DOB:_____

Address_____SSN:_____

Employer and Occupation:_____

Cell:_____ Work:_____ Home:_____

Emergency Contact Name_____ Phone:_____

Family History	**Yes**	**No**	**Relation to patient**
Ocular: Glaucoma	Y	N	
Cataract	Y	N	
Age-related macular degeneration	Y	N	
Detached retina	Y	N	
Cancer (of the eye)	Y	N	
Surgery	Y	N	
Keratoconus	Y	N	
Fuchs Endothelial Dystrophy	Y	N	
Other (color deficit, Retinitis Pigmentosa, etc)	Y	N	
Medical: High Blood Pressure	Y	N	
Diabetes Mellitus	Y	N	
Other (Please List)	Y	N	
Social History	**Yes**	**No**	**How often?**
Tobacco user?	Y	N	
Do you drink alcohol?	Y	N	
Do you use any recreational drugs?	Y	N	
Do you use a computer?	Y	N	
Are you pregnant or nursing?	Y	N	

History of Glasses? YES NO History of Contacts? YES NO Type/Brand?_____

Have you ever suffered a serious eye injury or had an eye surgery? YES NO Describe_____

Are you currently treated by another optometrist/ophthalmologist? YES NO For what?_____

How did you hear about us?_____

PLEASE FILL OUT THE BACK →

PERSONAL MEDICAL HISTORY / OCULAR HISTORY

REVIEW OF BODY SYSTEMS (PLEASE FILL OUT THE FOLLOWING HEALTH HISTORY AS IT PERTAINS TO YOU, THE PATIENT)

ALLERGIC/IMMUNOLOGIC ○ Drug Allergy ○ Environmental Allergy ○ Rheumatoid Arthritis ○ Lupus ○ Other:_____	**EYES** ○ Glaucoma ○ Cataract ○ Age related macular degeneration ○ Surgery/injury ○ Inflammation ○ Blurred vision ○ Double vision ○ Other: _____	**MUSCULOSKELETAL** ○ Fibromyalgia ○ Muscular dystrophy ○ Osteoarthritis ○ Ankylosing spondylitis ○ Other:_____	**CARDIOVASCULAR** ○ Heart disease ○ Hypertension ○ Stroke ○ Vascular disease ○ Other:_____
GASTROINTESTINAL ○ Crohn's disease ○ Colitis ○ Ulcer ○ Acid reflux ○ Hepatitis ○ Other:_____	**NEUROLOGICAL** ○ Multiple sclerosis ○ Epilepsy ○ Alzheimer's disease ○ Parkinson's disease ○ Cerebrovascular/stroke ○ Other:_____	**CONSTITUTIONAL** ○ Weight loss ○ Fever ○ Fatigue ○ Other:_____	**GENITOURINARY** ○ STD ○ Kidney ○ Enlarged prostate ○ Other:_____
PSYCHIATRIC ○ Depression ○ Panic disorder ○ Schizophrenia ○ Other:_____	**EAR,NOSE,MOUTH & THROAT** ○ Upper resp. tract infection ○ Ear ache ○ Runny nose ○ Sore throat ○ Ringing tinnitus ○ Other:_____	**HEMATOLOGIC/LYMPHATIC** ○ Anemia ○ Large volume blood loss ○ Leukemia ○ Bleeding disorder ○ Other:_____	**RESPIRATORY** ○ Former smoker ○ Present smoker ○ Asthma ○ Bronchitis ○ Emphysema ○ Other:_____
ENDOCRINE ○ Non-insulin dependent diabetes ○ Insulin-dependent diabetes ○ Thyroid dysfunction ○ Hormonal dysfunction ○ Other:_____	**INTEGUMENTARY (skin)** ○ Eczema ○ Rosacea ○ Psoriasis ○ Other:_____		

Medications (please list or provide a list of any medications you are taking, prescriptions AND/OR over the counter with dosage):

_____

_____

_____

_____

_____

_____

Medication Allergies: _____

_____

I, _____, attest that all information provided is complete and accurate, and I am signing voluntarily.
Patient or Legal Guardian's Name (Print)

_____ _____

Patient or Legal Guardian's Signature Date