NORTH COAST EYE CARE PATIENT INFORMATION

TITLE: **MR. MRS. MISS MS DR.** LAST_____FIRST_____MI____
MALE____ FEMALE____ DOB_____SS#_____
ADDRESS_____CITY_____ST_____ZIP_____
HOME PHONE_____WORK #_____CELL#_____
EMPLOYER **OR** SCHOOL_____OCCUPATION **OR** GRADE_____
SPOUSE **OR** GUARDIAN NAME_____SPOUSE **OR** GUARDIAN EMPLOYER_____
SPOUSE **OR** GUARDIAN SS#_____SPOUSE **OR** GUARDIAN DOB_____
PREFERRED NAME:_____EMAIL_____

INSURANCE INFORMATION

***VISION PLAN NAME**_____ID#_____GROUP#_____
CARDHOLDER NAME_____DOB_____SS#_____
***MEDICAL PLAN NAME**_____ID#_____GROUP#_____
CARDHOLDER NAME_____DOB_____SS#_____

I HAVE SECONDARY INSURANCE____ I HAVE NO INSURANCE____ I HAVE A FLEX SPEND/HSA ACCOUNT____

REASON FOR YOUR VISIT:_____
*ARE YOU HAVING PROBLEMS WITH YOUR GLASSES OR CONTACTS?_____
*ARE YOU INTERESTED IN REFRACTIVE SURGERY? (LASIK) YES NO

MEDICAL HISTORY

*PRIMARY CARE PHYSICIAN_____PHONE_____LAST EXAM_____
*CURRENT MEDICATIONS (including over the counter, vitamins, birth control etc...) YOU MAY PROVIDE A LIST
_____
_____
*KNOWN ALLERGIES_____ NONE_____
*LIST SURGERIES AND DATES_____
_____
*DO YOU USE **tobacco** (_____) **alcohol** (_____) **recreational drugs**(_____)
quantity quantity quantity

*HEIGHT_____ *WEIGHT_____ *ARE YOU PREGNANT? YES NO *RACE: White Hispanic African American Asian
Other:_____

*CURRENT MEDICAL EYE CONDITIONS (circle those that apply):
glaucoma cataracts dry eye macular degeneration retinal detachment lazy eye NONE

LIFESTYLE

____I look at a computer screen for at least four hours a day ____I have prescription sunglasses
____I want the lightest, thinnest lenses available ____I have children (some conditions may be hereditary)

CONTACT LENS HISTORY

____I am interested in trying contact lenses for the first time
____I currently wear contact lenses What brand?_____Solution?_____

FAMILY MEDICAL HISTORY

FAMILY MEDICAL CONDITIONS (CHECK THOSE THAT APPLY)

DRY EYE	____	RELATIONSHIP_____	NONE_____
CATARACTS	____	RELATIONSHIP_____	
CORNEAL DYSTROPHY	____	RELATIONSHIP_____	
KERATOCONUS	____	RELATIONSHIP_____	
LAZY EYE	____	RELATIONSHIP_____	
CROSSED/TURNED EYE	____	RELATIONSHIP_____	
MACULAR DEGENERATION	____	RELATIONSHIP_____	
DIABETES	____	RELATIONSHIP_____	
GLAUCOMA	____	RELATIONSHIP_____	
RETINAL DETACHMENT	____	RELATIONSHIP_____	

OTHER_____ RELATIONSHIP_____

REVIEW OF SYSTEMS

CIRCLE IF YOU HAVE ISSUES WITH THE FOLLOWING...

Hay fever/allergies	Anemia	Blurred vision
Medicine allergies	High cholesterol	Double vision
Lupus	Skin	Crossed eyes
Sjogren's	Breasts	Flashes/floaters
Fever	Arthritis/Rheumatoid	Red eyes
Recent weight loss	Muscle/Joint pain	Mucus,discharge;eyes
Heart disorder	Headaches/migraines	Burning or itching
High blood pressure	Seizures	Sandy/Gritty feeling
Vascular disease	Multiple sclerosis	Eye pain, soreness
Sinuses	Nervous disorders	Light sensitiviy
Dry throat/mouth	Depression	Eye strain
Chronic ear infections	Asthma	Halos/glare
Diabetes	Shortness of breath	Loss of vision
Thyroid	Emphysema	
Other glands	Lung cancer	
Kidneys/bladder	Other cancer_____	NONE OF THE ABOVE

MEDICAL HEALTH RELEASE INORMATION

I HAVE FILLED OUT THE FRONT AND BACK OF THIS MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS IMPORTANT TO BRING A COPY OF MY MEDICATIONS EACH VISIT. I UNDERSTAND IF I USE INSURANCE BENEFITS FOR TODAY'S VISIT IT IS A CONTRACT BETWEEN ME AND MY INSURANCE COMPANY AND I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THEM.

AS PER THE HIPAA RELEASE, I ACKNOWLEDGE AND APPROVE THE RELEASE OF MEDICAL INFORMATION NEEDED FOR INSURANCE PURPOSES, FOR THE REFERRAL TO OTHER DOCTORS OR PROFESSIONALS, AND TO RELEASE MY PRESCRIPTION TO OTHER OPTICALS.

_____ _____

SIGNATURE DATE