**Welcome**

**From Dr. Patel & Kelleman:**

**We are happy to serve you in a friendly manner and provide the best in eye care.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: S M D W

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy holder Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we speak with regarding your care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses? Y N Which brand?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Would you like to consider a new brand? Y N

**Medical insurances might pay for your exam if there is a complaint or a medical need.** So check at least one symptom which may even possibly affect you.

Please check all that apply:

❒ Eye Pain ❒ Lids droop or twitch

❒ Excessive tearing ❒ Light sensitivity ❒ Distorted vision

❒ Itching ❒ Loss of Side Vision ❒ Headache Feeling in Eye

❒ Burning ❒ Double Vision ❒ Bump in eyelid

❒ Dryness ❒ Flashes of light ❒ Words move when reading

❒ Tired eyes ❒ Blackout vision ❒ Losing place when reading

❒ Red/Pink eyes ❒ Moving Floaters/Shadows ❒ Poor vision at night

❒ Foreign Body Sensation ❒ Eye strain/Fatigue ❒ Crusty/Mucous Eye

Other eye concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear Contact lenses? Y N If yes, do you sleep with them on your eyes? Y N

Do you wear glasses? Y N If yes, how old are your glasses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drive at night? Y N Do you plan on getting new glasses today? Y N

(most insurance companies do not cover this portion of exam known as “refraction”)

How many hours per week do you read: without computer: \_\_\_\_\_\_\_\_\_\_\_\_ with a computer: \_\_\_\_\_\_\_\_\_\_

Do you have a history of the following?

❒ Glaucoma ❒ Eye injury ❒ Corneal Disease ❒ Iritis ❒ Macular Degeneration

❒ Cataracts ❒ Eye Surgery ❒ Retinal Disease ❒ Lazy Eye ❒ Diabetic Eye Disease

Is there a family history of any of the above? Y N

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History and Review of Systems

Do you currently, or have you had any problem in the following areas?

Please check all that apply.

Neurological Ear/Nose/Throat Vascular/Cardiovascular

❒ Headache ❒Allergies/ hay fever ❒ Stroke

❒ Migraines ❒ Hearing Difficulty ❒ High blood pressure

❒ Seizures ❒ Runny Nose ❒ Heart Disease

❒ Sleep Disorder ❒ Swollen Glands ❒ Heart Attack

❒ Multiple Sclerosis ❒ Chronic Cough ❒ Arrhythmia

❒ Alzheimer’s ❒ Sinus Headache/Congestion

Respiratory Lymphatic Bones/Joint/ Muscle

❒ Asthma ❒ Anemia ❒ Rheumatoid Arthritis

❒ Chronic Bronchitis ❒ Sickle Cell ❒ Muscle Pain

❒ Emphysema ❒ Immune deficiency ❒ Joint Pain

❒ Sarcoidosis ❒ High cholesterol ❒ Fibromyalgia

Endocrine Gastrointestinal Other

❒ Thyroid Disorder ❒ Diarrhea ❒ Cancer Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❒ Diabetes ❒ Constipation ❒ Cold hand’s easily

❒ Pre-menopause ❒ Irritable Bowel Syndrome ❒ Recent Weight Change

Integumentary Genitourinary Psychiatric

❒ Lupus ❒ Kidney ❒ Depression/Anxiety

❒ Rash ❒ Prostate or bladder ❒ Bipolar

❒ Acne Rosacea ❒ STD ❒ Schizophrenia

Please list other diseases you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list medicines to which you are ***allergic***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medications and vitamins with dosages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List major surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Alcohol more than socially? Y N

Do you use illegal drugs? Y N

Are you pregnant or Nursing? Y N

Height \_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_

The following questions are related to Macular Degeneration, the most common cause of legal blindness:

Do you eat tuna, salmon, herring, anchovies, mackerel, or bluefish? Y N

Do you take omega 3 fish oil? Y N

Do you eat spinach, yellow corn, eggs, or kale? Y N

Do you regularly exercise? Y N

Do you use tobacco? Y N