Welcome to Effingham Eye Care

Today's Date:_____ **Select One**: ☐ Miss ☐ Mrs. ☐Ms. ☐ Mr. ☐ Dr. ☐ Rev.

Last Name:_____, First Name:_____, MI:_____

Mailing Address:_____

City:_____, State:_____ Zip Code:_____

Home Phone: _____ Day Phone: _____ Cell Phone: _____

Do we have permission to send you text messages to remind you of your appointments? Opt out any time: ☐ Yes ☐ No

Date of Birth:____ / _____ / _____ Age:_____ Nickname: _____

Patient's SSN:_____ Guardian/Spouse's Name: _____

Employer / School:_____ Occupation / Grade: _____

Insured's Name: _____ Insured's SSN: _____ Insured's DOB: _____

Primary Insurance Company: _____ Policy Number: _____

Secondary Insurance Company: _____ Policy Number: _____

**Email Address:_____
(Saves money, time, and trees… For appointment reminders / newsletter – opt out anytime within email.)

What is the major purpose of this visit?_____

Whom may we thank for referring you to our office?_____

If not referred, how did you hear about our office for your eye health needs?

Another Doctor ☐ Insurance ☐ Web: _____ ☐ Other: _____

********** **MEDICAL HISTORY QUESTIONNAIRE** **********

Last Eye Exam:_____ Last Medical Exam:_____

Name of Medical Doctor:_____ Dr.'s Phone:_____

Medical History Do you have any allergies to medications? ☐ No ☐Yes If yes, please list :_____

_____

List any medications you take (including oral contraceptives, aspirin, and over the counter medications):

_____

_____

List all major injuries, surgeries and / or hospitalizations you have had:_____

_____

List any eye problems or surgeries you have had: _____

Females, are you pregnant or nursing? ☐ No ☐ Yes

Do you currently wear glasses? ☐ No ☐ Yes Use of glasses: ☐ Full-time ☐ Reading Only ☐ Distance Only

Do you wear contacts? ☐ No ☐ Yes If no, are you interested in wearing contacts? ☐ No ☐ Yes

Social History

This information is kept strictly confidential; however, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe:

_____

Do you use tobacco products? ☐ No ☐ Yes If yes, type / amount / how long:_____
Do you drink alcohol? ☐ No ☐ Yes If yes, type / amount / how long:_____
Do you use illicit drugs? ☐ No ☐ Yes If yes, type / amount / how long:_____

Have you ever been exposed to or infected with: ☐ Hepatitis ☐ HIV ☐ TB ☐ Syphilis

Family History

Is there a family history (parents, grandparents, siblings, children) for any of the following conditions?

☐ Blindness ☐ Crossed Eyes ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment/Disease

Other _____

Review of Systems

Do **YOU** currently have problems in any of the following areas:

	NO	YES
CONSITUTIONAL		
Fever, Weight Loss/Gain	☐	☐
INTEGUMENTARY (Skin)	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Styes or Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐

	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Dry Mouth	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Mental Illness	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
VASCULAR/CARDIOVASCULAR		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain:

_____

_____