SUNSET EYECARE PATIENT HISTORY

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State/Zip: _____

Telephone (H): _____ Cell/Work: _____

SSN: _____ DOB: _____ Age: _____

E-mail address: _____

Occupation: _____ Employer: _____

Marital Status: ○ S ○ M Do you require nursing care: ○ Yes ○ No

Do you have health insurance: ☐ Medicare ☐ Medicaid ☐ Other: _____

Vision Insurance (list provider[s]): _____

How did you learn about our office (check all that apply): ☐ Internet ☐ Sunset Eyecare.com ☐ newspaper ad

☐ radio ad ☐ phone book ad ☐ referred by doctor ☐ referred by friend ☐ Other: _____

MEDICAL INFORMATION/REVIEW OF SYSTEMS

How is your general health? (check one) ○ Good ○ Fair ○ Poor

Do you have any health problems? Please list: _____

_____

Are you having any other problems with the following systems? Please check all that apply.

☐ Gastrointestinal	☐ Nervous	☐ Respiratory	☐ Diabetes
☐ Musculoskeletal	☐ Mental	☐ Integumentary (Skin)	
☐ Ears/Nose/Throat	☐ Cardiovascular	☐ Genitourinary	
☐ Allergic/Immunologic	☐ Blood/Lymph	☐ Endocrine (Hormonal)	

Please list **ALL MEDICATIONS,** hormones and birth control: _____

_____

Please list all allergies and drug reactions: _____

Please list all major surgeries, illnesses and the dates they occurred. _____

_____

Do you use cigarettes/tobacco? ○ Yes ○ No Alcohol: ○ Yes ○ No Other: _____

Date of last tetanus shot: _____

FAMILY HISTORY

Diabetes ○ Yes ○ No Relation: _____ Macular Degeneration: ○ Yes ○ No Relation: _____

Glaucoma ○ Yes ○ No Relation: _____ Retinal Detachment: ○ Yes ○ No Relation: _____

Blindness ○ Yes ○ No Relation: _____

PERSONAL EYE INFORMATION

Have you had any eye surgeries? ○ Yes ○ No Please list: _____

Have you had any eye injuries? ○ Yes ○ No Please list: _____

Do you have any known disease of the eye? ○ Yes ○ No Please list: _____

When was your last eye exam? _____ Doctor's Name: _____