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: ______________________________