# Fort Madison Eye Clinic

Date: ____________

First Name: __________________ MI: ____ Last Name: ______________________ Name Preferred: __________________

Social Security Number: ____________________________________ Birthdate: ______________________ Age: __________

Address: _________________________________ City: _______________________ State: ________ Zip: ____________

Home Phone: ____________________ Work Phone: __________________ Employer: ________________________________

**Minors:** Father's Name: ________________________________ SSN: ____________________ Birthdate: ______________

Employer: ____________________________________________________ Work Phone: __________________

Mother's Name: ____________________________ SSN: ________________________ Birthdate: _______________

Employer: ____________________________________________________ Work Phone: __________________

**Insurance Information:** *If you have insurance, Medicaid and/or Medicare, please have your cards ready to copy.*

Name of insured: ________________________________________ Relationship to patient: ______________________

Birthdate: ____________ SSN: ______________ Name of Employer: __________________ Work Phone: ____________

Insurance Company: _________________________________ Policy #: _____________________ Group #: ______________

**Additional Insurance:** *If you have insurance, Medicaid and/or Medicare, please have your cards ready to copy.*

Name of insured: ________________________________________ Relationship to patient: ______________________

Birthdate: ____________ SSN: ______________ Name of Employer: __________________ Work Phone: ____________

Insurance Company: _________________________________ Policy #: _______________________ Group #: ______________

## MEDICAL HISTORY

Date of last visual exam: ______________________ Doctor's Name: _____________________________________

Do you wear glasses? ___ No ___ Yes If yes, how old is your present pair of glasses? ______________________

Do you wear contact lenses? ___ No ___ Yes If yes, how old is your present pair of lenses? ___________________

Type of contact lenses: ___ Rigid ___ Soft ___ Extended Wear ___ Others Are they comfortable? Yes/No

Brand/Type of contact lenses you currently wear: ______________________________________________________

Please list all medications you are sensitive or allergic to: ________________________________________________

Please list all medications you are currently taking (include oral contraceptives, aspirin, over-the-counter medications and home remedies): __________________________________________________________________________

______________________________________________________________________________________________

Name of Medical Doctor: ____________________________________ Date of last medical exam: ____________________

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

______________________________________________________________________________________________

List any of the following that you have had: cross eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye surgery, or eye injury: ______________________________________________________

______________________________________________________________________________________________

Are you pregnant or nursing? ___ Yes ___ No

**Check if you have had any of the following:**

___ Burn/Ache/Itch/Tear
___ Change in vision
    ___ Near ___ Distance
___ Contact lens difficulty
___ Poor night vision or glare

___ Dizziness
___ Double vision
___ Dry eyes
___ Discharge
___ Sinus trouble

___ Eye pain
___ Flaking lids
___ Halos/spots
___ Headaches
___ Others ______________________________

___ Loss of sight
___ Perceptual difficulties
___ Styes on lids
___ Asthma

**OVER**

## Social History

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 illegal drugs? ❑ No ❑ Yes If yes, type/amount/how long: ______
Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

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

## Review of Systems

**Please check (✔) any of the following that applies to you:**

| | Yes | No |
|---|---|---|
| **Constitutional** | | |
| Fever, Weight Loss/Gain | ❑ | ❑ |
| **Integumentary** | | |
| Skin | ❑ | ❑ |
| **Neurological** | | |
| Headaches | ❑ | ❑ |
| Migraines | ❑ | ❑ |
| Seizures | ❑ | ❑ |
| **Endocrine** | | |
| Thyroid/Other Glands | ❑ | ❑ |
| **Ears, Nose, Mouth, Throat** | | |
| Allergies/Hay Fever | ❑ | ❑ |
| Sinus Congestion | ❑ | ❑ |
| Runny Nose | ❑ | ❑ |
| Post-Nasal Drip | ❑ | ❑ |
| Chronic Cough | ❑ | ❑ |
| Dry Throat/Mouth | ❑ | ❑ |
| **Respiratory** | | |
| Asthma | ❑ | ❑ |
| Chronic Bronchitis | ❑ | ❑ |
| Emphysema | ❑ | ❑ |
| **Vascular/Cardiovascular** | | |
| Diabetes | ❑ | ❑ |
| Heart Pain | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ |
| Vascular Disease | ❑ | ❑ |
| **Gastrointestinal** | | |
| Diarrhea | ❑ | ❑ |
| Constipation | ❑ | ❑ |
| **Genitourinary** | | |
| Genitals/Kidneys/Bladder | ❑ | ❑ |
| **Bones/Joints/Muscles** | | |
| Rheumatoid Arthritis | ❑ | ❑ |
| Muscle Pain | ❑ | ❑ |
| Joint Pain | ❑ | ❑ |
| **Lymphatic/Hematologic** | | |
| Anemia | ❑ | ❑ |
| Bleeding Problems | ❑ | ❑ |
| **Allergic/Immunologic** | ❑ | ❑ |
| **Psychiatric** | ❑ | ❑ |

## Family History

**Please check (✔) any of the following that applies to yourself or any blood relative:**

| Eye | Self | Relative | Relationship |
|---|---|---|---|
| Cataract | ❑ | ❑ | ______ |
| Macular Degeneration | ❑ | ❑ | ______ |
| Glaucoma | ❑ | ❑ | ______ |
| Lazy or Crossed Eyes | ❑ | ❑ | ______ |
| Blindness | ❑ | ❑ | ______ |
| Allergies | ❑ | ❑ | ______ |
| Diabetes | ❑ | ❑ | ______ |
| Eye Surgery | ❑ | ❑ | ______ |
| Eye Diseases | ❑ | ❑ | ______ |
| High Blood Pressure | ❑ | ❑ | ______ |
| Heart Disease | ❑ | ❑ | ______ |
| Stroke | ❑ | ❑ | ______ |
| Migraine Headaches | ❑ | ❑ | ______ |
| Pacemaker | ❑ | ❑ | ______ |
| Epilepsy | ❑ | ❑ | ______ |
| Thyroid Problems | ❑ | ❑ | ______ |
| Lupus | ❑ | ❑ | ______ |
| Arthritis | ❑ | ❑ | ______ |
| Kidney Disease | ❑ | ❑ | ______ |
| Cancer | ❑ | ❑ | ______ |
| Retinal Detachment/Disease | ❑ | ❑ | ______ |

## Authorization & Release

**I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor.**

Signature ______

Date ______

Doctor Signature:
Date:
______