Crete Family Eyecare

General Information

Last, First, MI: Preferred Name: Male / Female

Date of Birth: Social Security Number:

Street Address: P.O. Box:

City, State, Zip:

Home Phone: Cell Phone:

Email:

Would you like to receive messages by: Email: Y N Text: Y N

Marital Status: Married Single Divorced Widowed

Language: Race: Ethnicity:

Insurance Information

Vision Insurance Plan (if any)? ☐ VSP ☐ EyeMed ☐ Spectera ☐ NE Total Care ☐ UHC Community

Subscriber Name: DOB: SSN:

Please note that most insurances do NOT cover the *Refraction* or the *Contact Lens Evaluation*. You will be responsible for those fees at today's visit.

Patient Eye History

Date of Last Eye Exam:

Currently Wear Glasses? Y N

Currently Wear Contacts? Y N

If NO are you interested in Contact Lenses? Y N

Reason for Today's Visit?

Are you planning to get new glasses today?

☐ Yes ☐ No ☐ Only if prescription changes

Do you have a FAMILY history of any of the following? Circle all that apply & list relationship of family member.

Condition			Relationship
Cataracts	*Yes*	*No*	
Glaucoma	*Yes*	*No*	
Lazy Eye	*Yes*	*No*	
Macular Degeneration	*Yes*	*No*	
Retinal Problems	*Yes*	*No*	
Corneal Problems	*Yes*	*No*	
Diabetes	*Yes*	*No*	

Have you ever experienced, been diagnosed with, or treated for any of the following? Check all that apply.

- ☐ Headaches
- ☐ Dryness
- ☐ Blurry Vision
- ☐ Flashes/Floaters
- ☐ Double Vision
- ☐ Itchiness/Grittiness
- ☐ Crossed Eye/Eye Turn
- ☐ Iritis/Uveitis
- ☐ Corneal Problems
- ☐ Lazy Eye
- ☐ Tearing/Watering
- ☐ Glare/Halos around lights
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Trouble seeing at night
- ☐ Burning
- ☐ Retinal Problems

Have you ever had any eye injuries or surgeries?

☐ **Yes** ☐ **No**

If YES, please list:

Patient Medical/Social History

Have you ever been diagnosed or treated for the following health problems? Check all that apply.

- ☐ Developmental Disability
- ☐ Cancer
- ☐ Fatigue
- ☐ Hearing Loss
- ☐ Dry Mouth
- ☐ Sinusitis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Autism
- ☐ Depression/Anxiety
- ☐ ADD/ADHD
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Crohn's Disease
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Excema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Diabetes Type 1 or 2
- ☐ Thyroid Dysfunction
- ☐ High Cholesterol
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Have you ever had any major surgeries?

☐ Yes ☐ No

If YES, Please list:

____

____

____

Tobacco Use:

- ☐ Never Smoked
- ☐ Current Smoker
  - # of Years ____________
- ☐ Former Smoker
  - Discontinued: ____________

Alcohol Use:

- ☐ Current Drinker
  - ☐ Everyday
  - ☐ Socially
- ☐ Former Drinker
  - Discontinued: ____________
- ☐ Never

Who is your Primary Care Physician?

____

Town: ______________________________

If you have diabetes, please list the doctor who manages your diabetes, if different than your Primary Care Physician:

____

Allergies to Medications:

☐ Yes ☐ No

If YES, what medications are you allergic to?

____

____

Current Medications: ☐ **Copy Provided**

Please include all Prescription and Over the Counter

Medication Name:	Dosage:

How did you hear about our office?

- ☐ Referral from: ____________
- ☐ I am a previous patient of this office.
- ☐ This office takes my insurance
- ☐ Another Doctor
- ☐ Saw Sign/Building
- ☐ Facebook
- ☐ Newspaper
- ☐ Radio
- ☐ Yellow Pages
- ☐ Our Website
- ☐ Google

I authorize the release of any medical information necessary to process all insurance claims. I also authorize the release of payment for medical benefits directly to my physician. I am also aware that I am responsible for any charges that have not been paid, or been covered by my insurance.

Signature: ______________________________

Date: ______________________________