Advanced EyeCare CENTERS

Last Name: _____ First Name:_____

Preferred Name: _____ Parent/Guardian/POA: _____

Street Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: Y N

E-Mail Address: _____

Communication Preferred: Email Telephone Postal

Referred By: _____ Last Eye Exam: _____ Doctor: _____

Sex: M F Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Employment Status: _____

Employer: _____ Occupation: _____

Preferred Language (if other than English): _____

Race:

☐ Native American/Native Alaskan

☐ Asian

☐ Black/African American

☐ Hispanic

☐ Native Hawaiian/Other Pacific Island☐ White

Ethnicity:

☐ Hispanic/Latino

☐ Native Hawaiian/Other Pacific Island

☐ Not Hispanic/Latino

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient (Print): _____ Date: _____

Signature of Patient/ Pt Representative (if patient is a minor or an adult unable to sign): _____

Relationship of Patient Representative to Patient: _____

----------Release of Information----------

I, _____, give my permission for Advanced EyeCare to release my medical information

to the following family members: _____

PATIENT HEALTH HISTORY

Patient Name: _____ **DOB**: _____

Primary Care Physician: _____ **Date last seen**: _____

Medical/Family History (use back of sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy):

_____

_____

_____

List all major surgeries (Eye surgery included):

_____

_____

List any allergic reactions to medications or eye drops:

_____

_____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease/Condition

	Yourself			**Family Member**		**Women**
	Yes	No		Yes	No	
Cataract	☐	☐	Blindness	☐	☐	Are you pregnant?
Eye Turn	☐	☐	Eye Turn	☐	☐	☐ Yes ☐ No
Glaucoma	☐	☐	Glaucoma	☐	☐	
Macular Degeneration	☐	☐	Macular Degeneration	☐	☐	Are you breast feeding?
Retinal Detachment	☐	☐	Retinal Detachment	☐	☐	☐ Yes ☐ No

Other: _____

Review of Systems: **Please indicate below if you have or ever had problems with the following conditions:**

Allergic/Immunologic **Ear, Nose and Throat** **Gastrointestinal** **Skin/Integumentary** **Psychiatric**

☐ None ☐ None ☐ None ☐ None ☐ None ☐ Lupus (SLE) ☐ Sinusitis ☐ Crohn's Disease ☐ Eczema ☐ Depression
☐ Rheumatoid Arthritis ☐ Upper Respiratory ☐ Colitis ☐ Rosacea ☐ Bi-Polar
☐ Seasonal Allergies ☐ Tract Infection ☐ Acid Reflux/Ulcer ☐ Psoriasis ☐ Schizophrenia
☐ Other (i.e., Latex) ☐ Other ☐ Other ☐ Other ☐ Other

Cardiovascular **Endocrine/Glands** **Respiratory** **Muscle/Skeletal** **Genital/Urinary**

☐ None ☐ None ☐ None ☐ None ☐ None
☐ High Blood Pressure ☐ Diabetes ☐ Asthma ☐ Arthritis ☐ Urinary Tract Infection
☐ Heart Disease ☐ Hormone Dysfunction ☐ Bronchitis ☐ Fibromyalgia ☐ HIV Positive
☐ Stroke ☐ Thyroid Dysfunction ☐ Emphysema ☐ Ankylosing Spondylitis ☐ Herpes/Chlamydia
☐ Vascular Disease ☐ Other ☐ Other ☐ Other ☐ Other
☐ High Cholesterol

Hematologic/Lymphatic **Neurological** **General Health** **Social**

☐ None ☐ None ☐ None Tobacco Use:
☐ Anemia ☐ Multiple Sclerosis ☐ Weight Loss/Gain ☐ Current Smoker ☐ Former Smoker
☐ Leukemia ☐ Epilepsy ☐ Fever ☐ Non-Prescription Drugs _____
☐ Bleeding Disorder ☐ Tremors ☐ Fatigue ☐ Alcohol Consumption _____
☐ Other ☐ Other ☐ Trauma ☐ Weight_____ Height _____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____