Welcome to ***Eye Was Framed Eyecare***

(PLEASE PRINT)
Patient Name _____

Address _____

City _____ State _____ Zip _____

Guardian (if applicable) _____

Home Phone (_____)_____ or N/A

Cell (_____)_____

Work Phone (_____)_____

Email _____

Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email

Employer (or School) _____

Employment Status _____

Occupation (or Grade) _____

Today's Date _____

Date of Birth _____ Age _____ Sex _____

Social Security # _____

Last Eye Exam _____ Previous Doctor _____

Previous Doctor Location _____

Medical Insurance _____

Primary ID # _____

Primary Cardholder _____ DOB _____

Vision Insurance _____

Primary ID # _____

Primary Cardholder _____ DOB _____

How did you first hear about ***Eye Was Framed Eyecare****?*

☐ Google Search ☐ Insurance ☐ Referred by another health care practitioner

☐ Office sign ☐ Other _____ ☐ Referred by a friend, teacher or a relative

If so, whom may we thank? _____

Medical/Vision History

What is the main purpose of your visit? ☐ Glasses ☐ Contacts ☐ Eye discomfort ☐ Other _____

What do you like or don't like about your present contact lenses or eyeglasses? Comfort/Fit/Style/Other _____

Are you interested in LASIK Refractive Surgery? ☐ Yes ☐ No Are you pregnant or nursing? ☐ No ☐ Yes

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain:_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

_____

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

_____

List any history of crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye injuries or eye surgery _____

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes _____

Screen Time in hours: At work/school _____ At home _____ Type (Circle all that apply): Phone/Tablet Computer TV/Games

Do you wear glasses? ☐ No ☐ Yes If yes, how old is your present pair of lenses?_____

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

If yes, Type of contact lenses: ☐ Gas Perm ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Social History *This information is strictly confidential. However you may discuss this portion directly with the doctor is you prefer.*
☐ Yes, I would prefer to discuss my social history information directly with my doctor (check box)

Do you use tobacco products? ☐ No ☐ Yes Amount / how long? _____ Do you drink alcohol? ☐ No ☐ Yes Amount / how long? _____

Do you use illegal drugs? ☐ No ☐ Yes If yes, amount / how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ N/A

Please turn this form over and complete side two*

Review of Symptoms
Do you currently, or have you ever had any problems in the following areas:

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/ Gain	☐	☐	☐
INTEGUMENTARY (skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye / Lid	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
High Cholesterol	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease /Stroke	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOUTINARY			
Genitals/ Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle / Joint Pain	☐	☐	☐
Osteo Arthritis	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
PSYCHIATRIC			
Anxiety / Depression	☐	☐	☐
Bi-polar / Schizophrenia	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

Family History
Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment / Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
High Cholesterol	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	