Welcome To Warren Eye Care Center

Patient Info.

Date: _____

Name: _____M____F___

Address: _____

City/State/Zip: _____

SS#: _____ Birth date: ___/___/___

Phone #: _____

Employer: _____

Occupation: _____

Guarantor (Insured) Info.
(if other than self)

Name: _____

Address: _____

City/State/Zip: _____

SS#: _____ Birth date:___/___/___

Phone #: _____

Employer: _____

Occupation: _____

Relationship to patient:_____

Medical History

Last Eye Doctor Seen and When: _____
Do you wear: **Glasses** **Contacts?** How old is your present pair of **Glasses** _____ **Contacts** _____
List medications you take (including contraceptives, aspirin, OTC and home remedies): _____

_____
Please list **medicine allergies**: _____ Are you pregnant or nursing? **Y** **N**
List major surgeries/hospitalizations: _____

Family History

Has anyone in the patient's family **(blood relative)** had any of the following?

Blindness	Yes	No	*Who:*	**Cancer**	Yes	No	*Who:*
Cataracts	Yes	No	*Who:*	**Diabetes**	Yes	No	*Who:*
Crossed Eyes	Yes	No	*Who:*	**Heart Disease**	Yes	No	*Who:*
Glaucoma	Yes	No	*Who:*	**High BP**	Yes	No	*Who:*
Macular Degeneration	Yes	No	*Who:*	**Kidney Disease**	Yes	No	*Who:*
Retinal Disease	Yes	No	*Who:*	**Lupus**	Yes	No	*Who:*
Arthritis	Yes	No	*Who:*	**Thyroid Disease**	Yes	No	*Who:*

Social History

Do you: Use tobacco products? **Yes / No** Drink alcohol? **Yes / No** Use illegal drugs? **Yes / No**

Please circle if you have been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Do you have visual difficulty when driving? **Yes** **No** If so, explain: _____

Do you work at a computer for long periods? **Yes** **No**

Do you spend time outdoors? **Yes** **No** _____ hours/week

Are you exposed to chemicals or flying objects? **Yes** **No**

Are you interested in laser vision correction? **Yes** **No**

HIPPA Statement

I agree that Warren Eye Care Center has made their HIPPA Privacy Notice available to me at their reception desk.

_____ _____
Signature **Date**

Review of Systems

Do you have any problems in the following areas? Please circle Yes or No:

Integumentary (skin) Yes No

Neurological Yes No
- Headaches Yes No
- Migraines Yes No
- Seizures Yes No
- Other: _____

Eyes
- Loss of vision Yes No
- Blurred vision Yes No
- Distorted vision/halos Yes No
- Loss of side vision Yes No
- Double vision Yes No
- Dry eyes Yes No
- Mucous discharge Yes No
- Redness Yes No
- Sandy/Gritty feeling Yes No
- Itching Yes No
- Burning Yes No
- Foreign body sensation Yes No
- Excess tearing/watering Yes No
- Glare/light sensitivity Yes No
- Eye pain or soreness Yes No
- Sties or chalazion Yes No
- Flashes of light Yes No
- Floaters in vision Yes No
- Tired eyes Yes No
- Retinal disease Yes No
- Eye injury Yes No
- Glaucoma Yes No
- Cataracts Yes No
- Lazy eye Yes No
- Crossed eye Yes No
- Drooping eyelid Yes No
- Other: _____

Allergic/Immunologic
- Seasonal Allergies Yes No
- Lupus Yes No
- Other: _____

Ednocrine
- Diabetes Yes No
- Thyroid Yes No
- Other: _____

Ears, Nose, Mouth, Throat
- Sinus Yes No
- Runny nose Yes No
- Post-nasal drip Yes No
- Chronic cough Yes No
- Dry throat/mouth Yes No

Respiratory
- Asthma Yes No
- Chronic bronchitis Yes No
- Emphysema Yes No

Vascular/Cardiovascular
- Heart problems Yes No
- High blood pressure Yes No
- High cholesterol Yes No
- Vascular disease Yes No
- Other: _____

Gastrointestinal
- Gastric reflux Yes No
- Ulcers Yes No
- Other: _____

Genitourinary
- Bladder problems Yes No
- Kidney stones Yes No
- Other: _____

Bones/Joints/Muscles
- Rheumatoid arthritis Yes No
- Muscle pain Yes No
- Other: _____

Lymphatic/Hematologic
- Anemia Yes No
- Bleeding problems Yes No
- Other: _____

Psychiatric
- Depression Yes No
- Bipolar Yes No
- Other: _____

Constitutional
- Fever Yes No
- Weight loss/gain Yes No
- Other: _____

Referral Source

How did you first hear about our office?

Friend / Relative Who? _____
Yellow Pages
Health Care Provider Who? _____
Insurance Company
Newspaper
Other