EYEQVISION
Smart Doctors, Smart Care

Patient Information: (Please print clearly) Date:_____

(Circle one) Mr./Mrs./Ms./Miss./Dr./Rev./Minor Sex: Male/Female

Are you: Single Married Divorced Separated Widowed

Patient's Name:_____

Address:_____ City/State/Zip:_____

Home#:_____ Cell#:_____ Work#:_____

E-Mail: _____

Date of Birth:_____ Social Security#:_____

Employer:_____ Occupation:_____

Patient's Spouse/ Parent:_____ Employer:_____

Primary Care Physician:_____ Phone:_____

Emergency Contact:_____ Relationship:_____

Emergency Contacts Phone #:_____

How did you hear about Eye-Q-Vision?_____

Flexible Spending Account

A **Flexible Spending Account (FSA)** also known as a **flexible spending** arrangement, is a special **account** you put money into that you use to pay for certain out-of-pocket health care costs. You don't have to pay taxes on this money.

Do you or a member of your family participate in flex spending? YES____ NO____

MEDICAL HISTORY:

What eye problems are you presently experiencing? _____

_____ Do you currently wear: Eyeglasses___ , Contact Lenses___, Rx Sunglasses

Previous eye surgery or eye problems? _____

ROS: Do you have problems in the following areas? If "yes", please explain.

Constitutional (Fever, Weight loss)---------- Yes/No _____
Liver/Spleen---------- Yes/No _____
Skin/Breast---------- Yes/No _____
Head (Headaches, Aneurysm)---------- Yes/No _____
Ears, Nose, Throat, Mouth, Neck---------- Yes/No _____
Lungs/Breathing (Asthma)---------- Yes/No _____
Heart/Blood Vessels (Heart Attack/ High Blood Pressure)---------- Yes/No _____
Stomach/Intestines (Ulcers/Gastritis)---------- Yes/No _____
Genitals/Kidney/Bladder---------- Yes/No _____
Bones, Joints, Muscles (Arthritis)---------- Yes/No _____
Neurological Systems (Stroke)---------- Yes/No _____
Lymph Nodes/Swelling---------- Yes/No _____
Allergic, Immunologic/Blood (Includes HIV or AIDS)---------- Yes/No _____
Psychiatric---------- Yes/No _____
Endocrine (Diabetes, Thyroid)---------- Yes/No _____
Other: _____

PAST HISTORY:

List any medications you take / Dose / Number of times per day:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any major illnesses and injuries you had in the past: _____

_____

List any surgeries you have had in the past (i.e.: tonsils, appendix)_____

_____

Have you ever been hospitalized other than previously mentioned? If so, why? _____

_____

Do you have any allergies to any medications: Yes/No If so, list Medications; _____

_____

SOCIAL HISTORY:

Marital Status (circle one): Single Married Divorced Widowed Other

Present Occupation: _____

Do you smoke? Yes / No If yes, how many years? _____ How many packs a day? _____

Do you drink alcohol? Yes / No If yes, how many glasses a day / week / month? (circle one) _____

FAMILY HISTORY:

What is the health status or cause of death of your parents, siblings, or children? _____

Any health problems in the family? Circle yes or no. If yes, please indicate the relationship to patient:

Straismus (cross or wall-eyed)---------- Yes/No _____
Blindness---------- Yes/No _____
Corneal Disease---------- Yes/No _____
Cataract---------- Yes/No _____
Glaucoma---------- Yes/No _____
Macular Degeneration---------- Yes/No _____
Retinal Detachment---------- Yes/No _____
Arthritis---------- Yes/No _____
Cancer---------- Yes/No _____
Diabetes---------- Yes/No _____
Heart Attack---------- Yes/No _____
High Blood Pressure---------- Yes/No _____
Kidney Disease---------- Yes/No _____
Stroke---------- Yes/No _____
Thyroid Disease---------- Yes/No _____
Other---------- Yes/No _____

For In-office use only: Date and Initial

History reviewed: _____