



PATIENT IDENTIFYING INFORMATION				
LAST NAME <input type="checkbox"/> MR <input type="checkbox"/> MS <input type="checkbox"/> MISS <input type="checkbox"/> DR	FIRST NAME	MIDDLE	DATE OF BIRTH	AGE
HOME ADDRESS		CITY	ST	ZIP CODE
HOME PHONE	WORK OR CELL PHONE	EMAIL ADDRESS		
EMPLOYER (SCHOOL)	OCCUPATION (GRADE)	HOBBIES		
HOW DID YOU HEAR ABOUT OUR OFFICE				
<input type="checkbox"/> INSURANCE <input type="checkbox"/> MAILING AD	<input type="checkbox"/> PHONE BOOK <input type="checkbox"/> LOCATION	REFERRED BY: <input type="checkbox"/> FRIEND <input type="checkbox"/> DOCTOR	WHOM MAY WE THANK FOR REFERRING YOU?	
IF PATIENT IS UNDER 18 YEARS OF AGE				
NAME OF PARENT/GUARDIAN	HOME PHONE	CELL PHONE	RELATION TO PATIENT	
EMERGENCY CONTACT				
EMERGENCY CONTACT NAME	HOME PHONE	CELL PHONE	RELATION TO PATIENT	
MEDICAL INFORMATION				
NAME OF PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR	DATE OF LAST EYE EXAM	
MEDICAL INSURANCE COVERAGE				
Please note that your insurance REQUIRES us to collect the SPECIALST copayment every visit				
NAME OF MEDICAL INSURANCE CO.	POLICY HOLDER (EMPLOYEE)	POL. HOLDER BIRTH DATE	RELATION TO PATIENT	
GROUP NAME	GROUP NUMBER	INSURED ID NUMBER	INSUR. CO. PHONE #	
VISION INSURANCE COVERAGE				
NAME OF VISION INSURANCE CO.	POLICY HOLDER (EMPLOYEE)	POL. HOLDER BIRTH DATE	RELATION TO PATIENT	
GROUP NAME	GROUP NUMBER	INSURED ID NUMBER	INSUR. CO. PHONE #	

**DIGITAL RETINAL PHOTOGRAPHY**

Clearview Eye Care believes that using the best technology is crucial to maintaining good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Photography, which gives a high definition picture of your retina, interior blood vessels, and optic nerves. These images are vital in helping the doctor assess your risks for serious ocular diseases. The photos also serve as a very important baseline, so every year your eyes can be compared to past images to monitor for even the smallest changes.

- Yes, I would like to have Digital Retinal Photography performed today (additional fee of \$30)
- No, against the advice of my doctor, I am refusing retinal photos and understand the health risks involved

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DO YOU CURRENTLY:		ARE YOU INTERESTED IN	
<input type="checkbox"/> WEAR GLASSES	AGE OF YOUR CURRENT GLASSES _____	<input type="checkbox"/> CONTACT LENSES FOR EVERY DAY USE	
<input type="checkbox"/> USE CONTACTS	BRAND: _____	<input type="checkbox"/> CONTACTS LENSES FOR SPORTS	
		<input type="checkbox"/> CHANGING YOUR EYE COLOR	
		<input type="checkbox"/> CONTACTS FOR SOCIAL ACTIVITIES	
YOUR VISUAL FUNCTION. Please check all that apply			
<input type="checkbox"/> WORK ON COMPUTERS UNDER FLOURESCENT LIGHTING		<input type="checkbox"/> CONTACTS LENSES GET DRY AT LEAST ONCE A DAY	
<input type="checkbox"/> SPEND TIME OUT DOORS		<input type="checkbox"/> CONTACTS LENSES ARE NOT AS CLEAR AS YOU WOULD LIKE	
<input type="checkbox"/> EYES ARE SENSITIVE TO SUNLIGHT		<input type="checkbox"/> HAVE PROBLEMS WITH GLARE OR REFLECTIONS	
<input type="checkbox"/> YOU WOULD LIKE INFORMATION OF THINNER/LIGHTER LENSES		<input type="checkbox"/> DO YOU SOMETIMES EXPERIENCE DRY EYES	
DO YOU EXPERIENCE ANY OF THE FOLLOWING			
<input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> DRYNESS	<input type="checkbox"/> GLARE SENSITIVITY	<input type="checkbox"/> TIRED EYES
<input type="checkbox"/> BURNING	<input type="checkbox"/> EXCESS TEARING	<input type="checkbox"/> EYE/EYELID INFECTION	<input type="checkbox"/> SUDDEN VISION LOSS
<input type="checkbox"/> DISTORTED VISION	<input type="checkbox"/> EYE PAIN/SORENESS	<input type="checkbox"/> ITCHING	<input type="checkbox"/> OTHER
<input type="checkbox"/> DOUBLE VISION	<input type="checkbox"/> FLASHES OF LIGHT	<input type="checkbox"/> LOSS OF SIDE VISION	
<input type="checkbox"/> DROOPING EYELID	<input type="checkbox"/> FLOATERS IN VISION	<input type="checkbox"/> SANDY FEELING	
HAVE YOU HAD			
<input type="checkbox"/> CATARACT SUGERY	<input type="checkbox"/> EYE MUSCLE SURGERY	<input type="checkbox"/> RETINAL SURGERY	<input type="checkbox"/> LASIK/PRK SURGERY
			<input type="checkbox"/> TRAUMATIC EYE INJURY
VISION HISTORY Do you or any of your blood relatives have		MEDICAL HISTORY Do you or any of your blood relatives have	
F = father M = mother S = sibling GP = grandparent(s)		F = father M = mother S = sibling GP = grandparent(s)	
	<u>YOU</u>	<u>YOU</u>	<u>FAMILY MEMBER</u>
Amblyopia/lazy eye	<input type="checkbox"/>	F	M S GP
Blindness	<input type="checkbox"/>	F	M S GP
Cataracts	<input type="checkbox"/>	F	M S GP
Color Blindness	<input type="checkbox"/>	F	M S GP
Crossed/Turned eyes	<input type="checkbox"/>	F	M S GP
Diabetic Retinopathy	<input type="checkbox"/>	F	M S GP
Glaucoma	<input type="checkbox"/>	F	M S GP
Herpes Eye Disease	<input type="checkbox"/>	F	M S GP
Keratoconus	<input type="checkbox"/>	F	M S GP
Macular Degeneration	<input type="checkbox"/>	F	M S GP
Retinal Detachment	<input type="checkbox"/>	F	M S GP
Other Vision Disorders	<input type="checkbox"/>	F	M S GP
SOCIAL HISTORY			
Do You Smoke	NO YES _____	PACKS PER DAY	
Alcohol Use	NO YES _____	DRINKS PER WEEK	
FEMALES: ARE YOU			
<input type="checkbox"/> PREGNANT	_____	MONTHS	
<input type="checkbox"/> NURSING			
LIST ALLERGIES, INCLUDING DRUG ALLERGIES			
LIST ALL CURRENT MEDICATIONS			
Allergies	<input type="checkbox"/>	F	M S GP
Arthritis	<input type="checkbox"/>	F	M S GP
Blood disease (anemia, sickle)	<input type="checkbox"/>	F	M S GP
Breathing problems	<input type="checkbox"/>	F	M S GP
Cancer	<input type="checkbox"/>	F	M S GP
Cardiovascular (heart, carotid)	<input type="checkbox"/>	F	M S GP
Cholesterol, high	<input type="checkbox"/>	F	M S GP
Collagen disease (lupus)	<input type="checkbox"/>	F	M S GP
Diabetes	<input type="checkbox"/>	F	M S GP
Fatigue	<input type="checkbox"/>	F	M S GP
Fever blister/cold sores	<input type="checkbox"/>	F	M S GP
Gastro (stomach, colon)	<input type="checkbox"/>	F	M S GP
Genital, kidney, bladder	<input type="checkbox"/>	F	M S GP
Headaches/migraines	<input type="checkbox"/>	F	M S GP
Hearing impairment	<input type="checkbox"/>	F	M S GP
Hepatitis	<input type="checkbox"/>	F	M S GP
Herpes simplex/zoster	<input type="checkbox"/>	F	M S GP
High blood pressure	<input type="checkbox"/>	F	M S GP
HIV / AIDS	<input type="checkbox"/>	F	M S GP
Hormonal/ Thyroid disease	<input type="checkbox"/>	F	M S GP
Immunologic disease	<input type="checkbox"/>	F	M S GP
Muscle, bone, joint	<input type="checkbox"/>	F	M S GP
Neurologic (MS)	<input type="checkbox"/>	F	M S GP
Nose, Sinus, Throat	<input type="checkbox"/>	F	M S GP
Psych (anxiety, depression)	<input type="checkbox"/>	F	M S GP
Resp (asthma, emphysema)	<input type="checkbox"/>	F	M S GP
Sexually transmitted disease	<input type="checkbox"/>	F	M S GP
Skin (acne, eczema)	<input type="checkbox"/>	F	M S GP
Tuberculosis	<input type="checkbox"/>	F	M S GP
Weak/numbness of arm/leg	<input type="checkbox"/>	F	M S GP
Weight changes sudden	<input type="checkbox"/>	F	M S GP