

Excel Eyecare Optometry

Patient Information No Change

Last Name _____ First Name _____ MI _____ Date _____
 SSN _____ Birthdate _____ Sex M F Marital status Married Divorced Single Widowed
 Home Address _____ City _____ State _____ Zip _____
 E-mail _____ Home Phone _____ Mobil Phone _____
 Employer _____ Occupation _____ Work Phone _____
 Emergency contact _____ Phone _____ Referred by _____

Insurance Information No Change

Insurance Name	Member ID	Group #	Insured's Name	Insured's DOB	Relation to patient

Patient Medical History No Change

1. Date of last physical exam _____ Personal physician _____
2. Date of last eye exam _____ Doctor _____
3. Do you wear glasses? Yes No If yes, age of present glasses _____ contact lens? Yes No If yes, type _____
4. Do you have? (please circle yes or no)
 Eye strain Yes No Dry eyes Yes No Floaters Yes No Flashes of light Yes No Macular degeneration Yes No
 Eye pain Yes No Itchy eyes Yes No Double vision Yes No Blurred vision Yes No Severe or frequent headaches Yes No
5. Do you or any blood relatives have? (please circle yes or no)

	Self	Relative		Self	Relative		Self	Relative
Cataracts	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	Color blindness	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	Retinal disease	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
Glaucoma	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	Blindness or poor night vision	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	High blood pressure	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
Diabetes	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	Crossed or wall eyes	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>	High cholesterol	<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
6. Are you being treated for any medical condition? Yes No If yes, please list _____
7. Are you taking any medications? Yes No If yes, please list _____
8. Are you allergic to any medication including eye drops? Yes No If yes, please list _____
9. Do you have or have you ever had any eye disease, injury or surgery? Yes No If yes, please explain _____
10. Do you have problems with these systems? (please circle yes or no)
 Gastrointestinal Yes No Nervous Yes No Endocrine (glands) Yes No Cardiovascular Yes No Muscles / Bones Yes No
 Ears/Nose/Throat Yes No Urinary Yes No Blood / Lymph Yes No Respiratory Yes No Integumentary (skin) Yes No
 If yes to any, please explain _____
11. Do you drink? Yes No If yes, how often _____ smoke? Yes No If yes, how often _____
12. Have you ever used drug? Yes No If yes, please list _____

The information I have provide above is accurate and complete to the best of my knowledge. I authorize the release of any medical or other information necessary to process the insurance claim. I also authorize payment of my insurance benefits to Excel Eyecare Optometry for the service I have received. If under 18 years of age, parent signature required.

Patient Signature _____ Date _____

Doctor Use Only
 Reviewed by doctor Michelle A. Gan, OD Signature _____ Date _____