PT # _____

ACC #_____

WELCOME

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

Date_____

PATIENT INFORMATION

1. **Name: (first)** _____ **(middle)** _____ **(last)** _____
2. **Address: (street)** _____ **(city)** _____ **(state)** _____ **(zip)** _____
3. **Contact Information: Please indicate the best way(s) to reach you by using the check boxes below:**

   ☐ **Home: (_____)** _____ ☐ **Fax : (_____)** _____

   ☐ **Cell : (_____)** _____ ☐ **Text** ☐ **E-mail:** _____

4. **Sex: ☐ M, ☐ F** 5. **Age:** _____ 6. **Birthdate:** _____ 7. **SS #** _____
8. **☐ Single, ☐ Married, ☐ Widowed, ☐ Separated, ☐ Divorced** 9. **Occupation:** _____
10. **Employer/School:** _____ 11. **Work/Day Phone: (___ ___)** _____
12. **Employer Address: (street)** _____ **(city)** _____ **(state)** _____ **(zip)** _____
13. **Name of ☐ Spouse, ☐ Parent or ☐ Closest Relative:** _____
14. **Activities or Hobbies:**_____ 15. **Referred by:**_____

INSURANCE INFORMATION

1. **Is patient covered by insurance? ☐ Yes, ☐ No If the answer is No, skip this section.**
2. **Insurance Co:** _____ 3. **Group #** _____
4. **Member ID #** _____ 5. **Member Name:** _____
6. **Birthdate:** _____ 7. **Relationship to patient:** _____
8. **Is patient covered by additional insurance? ☐ Yes, ☐ No If the answer is No, skip this section.**
9. **Insurance Co:** _____ 10. **Group #** _____
11. **Member ID #** _____ 12. **Member Name:** _____
13. **Birthdate:** _____ 14. **Relationship to patient:** _____

ACCOUNT INFORMATION

1. **Who is responsible for this account?** _____ 2. **Birthdate:** _____
3. **SS #** _____ 4. **Relationship to patient:** _____
5. **List your family members:**_____

ACKNOWLEDGEMENT

Due to the current economy, it is requested that professional charges be paid on the date of service, that a deposit of at least one half the material charges be made when materials are ordered, and that the balance be paid when materials are dispensed. Your compliance with this helps us to keep costs down, and is appreciated.

I acknowledge that I received a copy of Elgin Family Eye Care-Toshio Nakajima, O.D./ Susan M. Penner, O.D./ Michael G. Kennedy, O.D./ Andrew J. Brauer, O.D's Notice of Privacy Practices.

Signature: _____ **Printed Name:** _____ **Date:** _____

EYE HEALTH HISTORY

1. **Last eye exam: When** _____, **Where/ Name of doctor**_____

2. **Do you wear glasses? □ Yes, □ No, □ All the time, □ Occasionally, □ Reading, □ Driving, □ TV, □ Work**

3. **Do you wear contact lenses? □ Yes, □ No, Type/Brand:**_____, **Wearing Time:** _____**Hours/days**

4. **Eye symptoms: Place a mark on "Yes" or "No" to indicate if you have any of the following:**

Bloodshot Eyes	**□ Yes, □ No**	**Headaches**	**□ Yes, □ No**
Blurred Vision - Distance	**□ Yes, □ No**	**Itching Eyes**	**□ Yes, □ No**
Blurred Vision – Near	**□ Yes, □ No**	**Light Sensitivity**	**□ Yes, □ No**
Burning Eyes	**□ Yes, □ No**	**Night Vision Problems**	**□ Yes, □ No**
Color Vision Problem	**□ Yes, □ No**	**Seeing Flashes**	**□ Yes, □ No**
Crossed (Turned) Eye	**□ Yes, □ No**	**Side Vision Problem**	**□ Yes, □ No**
Discharge from Eyes	**□ Yes, □ No**	**Twitching Eyelid**	**□ Yes, □ No**
Dizzy Spells	**□ Yes, □ No**	**Vision Loss**	**□ Yes, □ No**
Double Vision	**□ Yes, □ No**	**Watering Eyes**	**□ Yes, □ No**
Dry Eyes	**□ Yes, □ No**	**Cataracts**	**□ Yes, □ No**
Eye Infection	**□ Yes, □ No**	**Eye Surgery**	**□ Yes, □ No**
Eye Injury	**□ Yes, □ No**	**Glaucoma**	**□ Yes, □ No**
Eye Pain	**□ Yes, □ No**	**Lazy Eye**	**□ Yes, □ No**
Eye Strain	**□ Yes, □ No**	**Macular Degeneration**	**□ Yes, □ No**
Floaters or Spots	**□ Yes, □ No**	**Retinal Disease**	**□ Yes, □ No**

4. **Describe any problems you have with your eyes or vision.** _____

_____

HEALTH HISTORY

1. **Last general health exam: When**_____, **Where/Name of doctor**_____

2. **Height:** _____**ft** _____**inches Weight:** _____**lbs Race/Ethnicity:** _____

2. **Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative had any of the following problems:**

	Yourself	**Family Members**		**Yourself**	**Family Members**
AIDS/HIV	**□ Yes, □ No**	**□ Yes, □ No**	**Hepatitis / Jaundice**	**□ Yes, □ No**	**□ Yes, □ No**
Anxiety / Depression	**□ Yes, □ No**	**□ Yes, □ No**	**High Blood Pressure**	**□ Yes, □ No**	**□ Yes, □ No**
Arthritis	**□ Yes, □ No**	**□ Yes, □ No**	**High Cholesterol**	**□ Yes, □ No**	**□ Yes, □ No**
Asthma	**□ Yes, □ No**	**□ Yes, □ No**	**Kidney Disease**	**□ Yes, □ No**	**□ Yes, □ No**
Bleeding / Anemia	**□ Yes, □ No**	**□ Yes, □ No**	**Lupus**	**□ Yes, □ No**	**□ Yes, □ No**
Cancer	**□ Yes, □ No**	**□ Yes, □ No**	**Migraine Headaches**	**□ Yes, □ No**	**□ Yes, □ No**
Chemical Dependency	**□ Yes, □ No**	**□ Yes, □ No**	**Multiple Sclerosis**	**□ Yes, □ No**	**□ Yes, □ No**
Diabetes	**□ Yes, □ No**	**□ Yes, □ No**	**Sarcoidosis**	**□ Yes, □ No**	**□ Yes, □ No**
Dry Mouth	**□ Yes, □ No**	**□ Yes, □ No**	**Sinus Infection**	**□ Yes, □ No**	**□ Yes, □ No**
Emphysema / COPD	**□ Yes, □ No**	**□ Yes, □ No**	**Shingles**	**□ Yes, □ No**	**□ Yes, □ No**
Epilepsy	**□ Yes, □ No**	**□ Yes, □ No**	**Skin Condition**	**□ Yes, □ No**	**□ Yes, □ No**
Fatigue, Weight Change	**□ Yes, □ No**	**□ Yes, □ No**	**Sleep Apnea**	**□ Yes, □ No**	**□ Yes, □ No**
Fever, Nausea, Vomiting	**□ Yes, □ No**	**□ Yes, □ No**	**Stroke**	**□ Yes, □ No**	**□ Yes, □ No**
Head or Neck Trauma	**□ Yes, □ No**	**□ Yes, □ No**	**Thyroid Condition**	**□ Yes, □ No**	**□ Yes, □ No**
Heart Condition	**□ Yes, □ No**	**□ Yes, □ No**	**Tuberculosis**	**□ Yes, □ No**	**□ Yes, □ No**

3. **Tobacco use: □ Yes □ Never □ Former Smoker**
4. **Question for females: Are you Pregnant/Nursing? □ Yes, □ No**
5. **Alcohol use: □ Yes □ No**

5. **Medications: List Medications you are currently taking, including eye drops :** _____

_____

_____

6. **Allergies: List your allergies (Environmental/Seasonal AND Allergies to Medications/Other) :** _____

_____

7. **Health concerns or explanations :** _____

_____

8. **Remarks :**_____

_____