Welcome to our Practice

To help us understand your history, specific needs and concerns, please complete the information below:

Date ________________

Patient Name _______________________________
Parent or Guardian __________________________
Address ___________________________________
City/Town __________________________________

Email ____________________________________
Employer __________________________________
Referred to our office by _____________________

Birthdate _______________________________________
*SSN*____________________ _______________________
Primary Care Physician ___________________________
Home Phone ____________________________________
*Work P hone*____________________________________
Cell Phone ____________________________________
Occupation _____________________________________

Eye History

Do you currently wear: *Glasses* *Contact Lenses* *Neither*
Are you currently taking prescription or non prescription medication for your eyes? No Yes
If yes, please list ____
Have you ever had eye surgery, laser treatment, intraocular injections? No Yes
If yes, please list ____
Have you ever injured your eye? No Yes
If yes, please explain ____

Have you ever experienced any of the following? (Circle "no" or "yes", leave blank if uncertain)

Glaucoma, Cataracts, Etc	*No*	*Yes*	*Sandy or Gritty*	*No*	*Yes*
Driving: decrease at nighttime	*No*	*Yes*	*Itching*	*No*	*Yes*
Increase in light sensitivity	*No*	*Yes*	*Stinging*	*No*	*Yes*
Blurred Vision	*No*	*Yes*	*Burning*	*No*	*Yes*
Fluctuating Vision	*No*	*Yes*	*Foreign Body Sensation*	*No*	*Yes*
Distorted Vision	*No*	*Yes*	*Excess Tearing*	*No*	*Yes*
Loss of Vision	*No*	*Yes*	*Glare/Light Sensitivity*	*No*	*Yes*
Loss of Side Vision	*No*	*Yes*	*Pain or Soreness*	*No*	*Yes*
Double Vision	*No*	*Yes*	*Infection*	*No*	*Yes*
Dryness	*No*	*Yes*	*Tired Eyes*	*No*	*Yes*
Mucous Discharge	*No*	*Yes*	*Drooping Eyelid*	*No*	*Yes*
Redness	*No*	*Yes*	*Lazy Eye/Crossed Eye*	*No*	*Yes*

Explain:
____
____

Medical History *Date of most recent physician visit:*_______________________

Are you currently being treated for any of the following:

High Blood Pressure	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
High Cholesterol	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
Diabetes	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
Heart Disease	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
Stroke	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
Arthritis	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
Cancer	*No*	*Yes*	*When was the condition 1st diagnosed* _________________________
Thyroid	*No*	*Yes*	*When was the condition 1st diagnosed*_________________________

Medications (include non prescription)

____ ____
____ ____
____ ____

Previous Hospitalizations/surgeries/serious illnesses: ***When:***

____ __________________________
____ __________________________
____ __________________________

Patient Social History (circle appropriate answer)

Use of Alcohol *Never* *Rarely* *Moderate* *Daily*
Use of Tobacco *Never* *Previously, but not in _______ year(s)* *Current packs/day ________*

Review of Systems:

Are you currently experiencing problems with any of the following (Circle Yes or No – if uncertain, leave blank)

Sudden weight gain or loss	*No*	*Yes*
Chronic fever or chronic fatigue	*No*	*Yes*
Heart *(example: chest pain, angina, irregular heart beat)*	*No*	*Yes*
Respiratory *(example: coughing, wheezing, shortness of breath, asthma)*	*No*	*Yes*
Ear/Nose/Throat *(example: sore throat, sinus problem, ear ache, hearing loss)*	*No*	*Yes*
Gastrointestinal *(example: abdominal pain, heartburn, bowel problems, vomiting)*	*No*	*Yes*
Urinary *(example: pain when urinating, blood in urine)*	*No*	*Yes*
Hematologic/Lymphatic *(example: blood disorders, bruising, cuts heal slowly, enlarged glands)*	*No*	*Yes*
Endocrine *(example; thyroid problems)*	*No*	*Yes*
Integumentary *(example: rashes, dry skin, rosacea)*	*No*	*Yes*
Musculoskeletal *(example: joint pain, stiffness or weakness)*	*No*	*Yes*
Neurological *(example: numbness, headache, seizures, paralysis)*	*No*	*Yes*
Psychiatric *(example:depression, anxiety, insomnia, confusion)*	*No*	*Yes*
Allergic/Immunologic *(example: reaction to food or drugs, allergies, hay fever)*	*No*	*Yes*

*Explain:*____
____

Family Medical History (List Medical and Eye Disease)

Father ____
*Mother*____
*Siblings*____
____
____

Lifestyle/Activities/Hobbies (Check the box which apply to you)

___ *Computer Use* ___ *Swimming* ___ *Cycling* ___ *Lacrosse*
___ *Driving* ___ *Running/Walking* ___ *Sailing/Boating* ___ *Soccer*
___ *Work related driving* ___ *Gym sports* ___ *Fishing* ___ *Cooking*
___ *Painting/Drawing* ___ *Golf* ___ *Baseball/Softball* ___ *Needlework*
___ *Music* ___ *Tennis* ___ *Skiing* ___ *Time at the Beach*

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I will provide Sakonnet Eye Care with my health insurance and vision carrier information. I authorize Sakonnet Eye Care to file insurance claims on my behalf. I understand I am responsible for any fees not covered by these carriers and I will pay the balance promptly.

____ __________________________
Signature of patient or Guardian if Minor *Date*

Doctor's Review ________________________ ________________________
Signature *Date*

Doctor's Review ________________________ ________________________
Signature *Date*

Doctor's Review ________________________ ________________________
Signature *Date*

Doctor's Review ________________________ ________________________
Signature *Date*

Doctor's Review ________________________ ________________________
Signature *Date*