## *Welcome to Our Office*

Date_____ Email Address_____
Patient's Name_____ Age_____ Date of Birth_____ Sex: ❑ M ❑ F
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino Race: ❑ White/Caucasian ❑ Black/African American
❑ American Indian/Alaska Native ❑ Native Hawaiian/Pacific Islander ❑ Asian ❑ Some other race ❑ Two or more races
Address_____
Street City State Zip
Telephone (Home) (____)_____(Work) (____)_____(Mobile) (____)_____
Social Security Number_____ Parent's Name (if minor)_____ Spouse's Name_____
If Student, Grade_____ School_____ Occupation _____
Responsible Party for Account_____ Relationship to Patient_____
Payment Preference ❑ Cash ❑ Check ❑ Visa/MC/Discover/AmEx Do you have insurance? ❑ Yes ❑ No
If you have insurance, please list insurance provider_____ I.D. number_____
Who referred you to our office?_____
Who may we contact in case of an emergency?_____ Telephone (___)_____

## Eye History/Ocular Review of Systems

Approximate date of last eye examination _____ By Doctor _____
Do you wear glasses? ❑ Yes ❑ No If yes, when were they prescribed?_____
Do you wear contact lenses? ❑ Yes ❑ No If yes, when were they prescribed?_____
Would you like to wear contact lenses? ❑ Yes ❑ No Have you ever worn contact lenses? ❑ Yes ❑ No
Are you interested in refractive surgery (LASIK)? ❑ Yes ❑ No Have you ever received eye exercises? ❑ Yes ❑ No
Do you wear sunglasses? ❑ Yes ❑ No Do you feel your vision problems occur at ❑ Distance ❑ Near ❑ Both ❑ Neither
Do you currently have or have you ever had any of the following problems?

| | | |
|---|---|---|
| ❑ Loss of Vision | ❑ Excess Tearing/Watering | ❑ Eye Pain |
| ❑ Blurred Vision | ❑ Mucous Discharge | ❑ Eye Infections |
| ❑ Distorted Vision/Halos | ❑ Redness | ❑ Eye Injuries |
| ❑ Loss of Side Vision | ❑ Itching | ❑ Eye Surgery |
| ❑ Double Vision | ❑ Burning | ❑ Retinal Detachment/Disease |
| ❑ Dry Eyes | ❑ Foreign Body Sensation | ❑ Cataracts |
| ❑ Floaters in Vision | ❑ Sandy or Gritty Feeling | ❑ Glaucoma |
| ❑ Flashes of Light in Vision | ❑ Eye Strain/Tired Eyes | ❑ Macular Degeneration |
| ❑ Twitching Eye Lids | ❑ Light Sensitivity/Glare | ❑ Crossed Eyes/Lazy Eye |
| | | ❑ Keratoconus |

## Medical History

Are you presently taking any medications (including OTC medications, hormones, supplements, or birth control)? ❑Yes ❑ No
If yes, please list and include dosage_____
_____
Do you have any allergies to medications? ❑ Yes ❑ No If yes, please list _____
List all major injuries, surgeries, and/or hospitalizations you have had_____
_____
Are you pregnant and or nursing? ❑ Yes ❑ No
Approximate date of last general health exam _____Family Physician_____
Address_____ Phone Number (___)_____

## Family History

Please note any family history (parents, grandparents, siblings, children, aunts, uncles) for the following conditions:

| **Condition** | **Yes** | **No** | **?** | **Relationship to You** |
|---|---|---|---|---|
| Blindness | ❑ | ❑ | ❑ | _____ |
| Cataracts | ❑ | ❑ | ❑ | _____ |
| Glaucoma | ❑ | ❑ | ❑ | _____ |
| Crossed Eyes/Lazy Eye | ❑ | ❑ | ❑ | _____ |
| Macular Degeneration | ❑ | ❑ | ❑ | _____ |
| Retinal Detachment/Disease | ❑ | ❑ | ❑ | _____ |
| Keratoconus | ❑ | ❑ | ❑ | _____ |
| Diabetes | ❑ | ❑ | ❑ | _____ |
| High Blood Pressure | ❑ | ❑ | ❑ | _____ |
| Heart Disease | ❑ | ❑ | ❑ | _____ |
| Thyroid Disease | ❑ | ❑ | ❑ | _____ |
| Rheumatoid Arthritis | ❑ | ❑ | ❑ | _____ |
| Cancer | ❑ | ❑ | ❑ | _____ |

***Please turn this sheet over and complete the other side.***

## Review of Systems

Do you currently or have you ever had any problems in the following areas?

| System | Yes | No | ? |
|---|---|---|---|
| **Constitutional** (fever, weight loss, gain) | ❑ | ❑ | ❑ |
| **Integumentary** (skin) | ❑ | ❑ | ❑ |
| **Neurological** | | | |
| Headaches/Migraines | ❑ | ❑ | ❑ |
| Seizures | ❑ | ❑ | ❑ |
| Multiple Sclerosis | ❑ | ❑ | ❑ |
| **Ears, Nose, Mouth, Throat** | | | |
| Allergies, Hay Fever | ❑ | ❑ | ❑ |
| Sinus Congestion | ❑ | ❑ | ❑ |
| Runny Nose | ❑ | ❑ | ❑ |
| Chronic Cough | ❑ | ❑ | ❑ |
| Dry Throat/Mouth | ❑ | ❑ | ❑ |
| **Cancer** | ❑ | ❑ | ❑ |
| **Respiratory** | | | |
| Asthma | ❑ | ❑ | ❑ |
| Chronic Bronchitis | ❑ | ❑ | ❑ |
| Emphysema | ❑ | ❑ | ❑ |
| **Psychiatric** | ❑ | ❑ | ❑ |
| **Allergic/Immunologic** | ❑ | ❑ | ❑ |
| **Endocrine (thyroid/other glands)** | ❑ | ❑ | ❑ |

| | Yes | No | ? |
|---|---|---|---|
| **Vascular/Cardiovascular** | | | |
| Diabetes | ❑ | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ | ❑ |
| Heart Attack | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ |
| Heart Disease/Pain | ❑ | ❑ | ❑ |
| High Cholesterol | ❑ | ❑ | ❑ |
| **Gastrointestinal** | | | |
| Constipation | ❑ | ❑ | ❑ |
| Diarrhea | ❑ | ❑ | ❑ |
| Ulcers | ❑ | ❑ | ❑ |
| Acid Reflux | ❑ | ❑ | ❑ |
| **Genitourinary** (genitals/kidney/bladder) | ❑ | ❑ | ❑ |
| **Bones/Joints/Muscles** | | | |
| Rheumatoid Arthritis | ❑ | ❑ | ❑ |
| Osteoarthritis | ❑ | ❑ | ❑ |
| Muscle Pain | ❑ | ❑ | ❑ |
| Joint Pain | ❑ | ❑ | ❑ |
| **Lymphatic/Hematologic** | | | |
| Anemia | ❑ | ❑ | ❑ |
| Bleeding Problems | ❑ | ❑ | ❑ |

## Social History

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

❑ Yes, I would prefer to discuss this information with the doctor.

Employer_____ Address_____

Are you: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Do you use a computer or a tablet? ❑Yes ❑ No

Do you drive? ❑ Yes ❑ No What are some of your hobbies?_____

Do you smoke? ❑ Yes ❑ No If yes, type/amount/how long:_____

Have you ever smoked? ❑ Yes ❑ No If yes, type/amount/how long:_____

Do you use other tobacco products? ❑ Yes ❑ No If yes, type/amount/how long:_____

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long:_____

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long:_____

Have you ever been exposed to/infected with any of the following? ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis ❑None

## Authorization

*I certify that the above questions have been accurately answered to the best of my knowledge. I authorize the doctor to release any information including the diagnosis and the records of any treatment given to me or my dependents to third party payers and/or health practitioners. If applicable, I authorize my insurance company to pay directly to the doctor insurance benefits on my behalf. I understand that my insurance carrier may pay less than the actual bill for services and may not cover some items, tests, or procedures. I understand that in order to receive a prescription for eyeglasses, a refraction must be performed and there is a charge for it. I understand that in order to receive a prescription for contact lenses, a refraction and a contact lens fitting or evaluation must be performed and there is a charge for them. If I am unsure as to what my insurance covers, I will ask the office staff for an explanation prior to receiving any services. I agree to be ultimately responsible for payment of services rendered to me or my dependents. I agree that Manchester Eye Care may communicate with me via phone calls, voice messages, text messages, or email. I acknowledge that I have read Manchester Eye Care, LLC's Notice of Privacy Practices and may download a copy of it at manchestereyecare.com.*

_____ _____

Signature of Patient (or parent if minor) Date

_____ O.D. _____

Doctor's Signature Date