Welcome to DePoe Eye Center DATE: _____

We want to welcome you to our practice and appreciate that you have chosen us as your family eye care provider. We believe that there is still a personal touch in medical eye care and strive to offer that family relationship to our patients. This diagnostic form will help us in evaluating both your vision and your total eye and body health. Please take a few moments to complete it. Again, welcome to DePoe Eye Center. PLEASE USE BLACK INK

NAME: LAST: _____ FIRST: _____ M.I. _____ Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Hobbies/Interests: _____ Email Address: _____

Medical Insurance: _____ Vision Insurance: _____

Secondary Insurance (if applicable): _____

May we contact you by: ☐ CELL PHONE ☐ HOME PHONE ☐ WORK PHONE ☐ EMAIL ☐ TEXT

How were you referred to our office?

☐ Friend or family member: _____ ☐Insurance Company ☐ Yellow Pages
☐ Family Doctor: _____ ☐ Received Mailing ☐ Newspaper
☐ Ophthalmologist: _____ ☐ Internet ☐Other: _____

If this form was filled out by someone other than the patient, please list name and relation: _____

OCULAR HISTORY

Have you ever been diagnosed with any of the following conditions?

Cataract	☐ Y	☐ N
Glaucoma	☐ Y	☐ N
Dry Eye	☐ Y	☐ N
Eye Infection	☐ Y	☐ N
Eye Allergy	☐ Y	☐ N
Iritis/Uveitis	☐ Y	☐ N
Lazy Eye	☐ Y	☐ N
Eye Turn	☐ Y	☐ N
Diabetes	☐ Y	☐ N
Diabetic Retinopathy	☐ Y	☐ N
Macular Degeneration	☐ Y	☐ N
Eye Inflammation	☐ Y	☐ N
Flashes or Floaters	☐ Y	☐ N
Retinal Degeneration	☐ Y	☐ N
Retinal Detachment	☐ Y	☐ N
Eye accident/trauma	☐ Y	☐ N

Any other eye conditions? _____

_____

Have you had any EYE surgeries? ☐ Y ☐ N

_____

_____

Do you have any of the following?

Redness	☐ Y	☐ N
Tearing	☐ Y	☐ N
Burning	☐ Y	☐ N
Itching	☐ Y	☐ N
Discharge	☐ Y	☐ N
Glare	☐ Y	☐ N

Eyeglass / Contact Lens History

Do you currently wear glasses?	☐ Y	☐ N
Do you currently wear contacts?	☐ Y	☐ N
Planning on purchasing glasses today?	☐ Y	☐ N
Interested in wearing contact lenses?	☐ Y	☐ N

MEDICAL HISTORY

Date of last eye exam: _____

Where did you get your last eye exam: _____

Date of last medical exam: _____

Name of Primary Care Physician: _____

Review of Systems: Many diseases of the body have serious eye health consequences. Please answer the following questions related to your overall health. While they may seem unrelated to an eye problem, it is crucial to your care that we ask them.

Do you have any of the following problems?

General Health ☐ Y ☐ N
Chronic fever, unexpected weight loss/gain, fatigue
Ear/Nose/Throat ☐ Y ☐ N
Hearing loss, sinus problems, sore throat
Neurologic ☐ Y ☐ N
Numbness, weakness, headaches, “blackouts”, MS
Psychiatric ☐ Y ☐ N
Depression, anxiety
Cardiovascular ☐ Y ☐ N
High Blood pressure, heart disease, high cholesterol
Respiratory ☐ Y ☐ N

Shortness of breath, wheezing, coughing, asthma
Gastrointestinal ☐ Y ☐ N
Heartburn, reflux, abdominal pain, diarrhea, vomiting
Genitourinary ☐ Y ☐ N
Painful urination, blood in urine, sex organ problems
Musculoskeletal ☐ Y ☐ N
Arthritis, joint pain, muscle pain
Skin/Integumentary ☐ Y ☐ N
Rashes, excessive dryness, growths, lumps, eczema
Endocrine ☐ Y ☐ N
Diabetes, high or low thyroid, heat/cold intolerant
Blood/Lymph ☐ Y ☐ N
Bruising, unusual paleness, swollen glands, anemia
Immune ☐ Y ☐ N
Frequent infections, allergic reactions, Lupus

Do you have problems with excessive snoring or diagnosed sleep apnea? ☐ Y ☐ N

Females: Are you pregnant? ☐ Y ☐ N
Nursing? ☐ Y ☐ N

Have you ever been treated for any medical conditions? (Ex. Diabetes, hypertension, high cholesterol, arthritis, etc) ☐ Y ☐ N
If yes, please explain: _____
_____
_____

Have you had any surgeries? ☐ Y ☐ N
If yes, please explain: _____
_____

Do you take any medications, including over the counter medications? ☐ Y ☐ N
PLEASE LIST: _____
_____
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_____

Do you have any **DRUG**, FOOD or ENVIRONMENTAL allergies? ☐ Y ☐ N ☐ NKDA ☐ KDA
PLEASE LIST: _____
_____
_____

FAMILY MEDICAL HISTORY: Do any MEDICAL diseases run in your family (BLOOD relatives)?

Condition			Relative
Diabetes	☐ Y	☐ N	_____
Hypertension	☐ Y	☐ N	_____
Thyroid	☐ Y	☐ N	_____
Cancer	☐ Y	☐ N	_____

FAMILY OCULAR HISTORY: Do any EYE diseases run in your family (BLOOD relatives)?

Condition			Relative
Glaucoma	☐ Y	☐ N	_____
Macular Degen	☐ Y	☐ N	_____
Cataract	☐ Y	☐ N	_____
Blindness	☐ Y	☐ N	_____

SOCIAL HISTORY:
Do you drink alcohol? ☐ Y ☐ N
☐Occasionally ☐1/day ☐2-3/day ☐4+/day
Do you smoke or use tobacco products? ☐ Y ☐ N
☐Occasionally ☐_____ pack/day ☐>2 packs/day

Pharmacy Information:
Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone #: _____

Physician Notes: ◉ NKDA ○ KDA
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