WELCOME TO CATES FAMILY EYE CARE

Patient Information

Patient Legal Name ____ DOB _______________

Address ____ SSN __________________

City ____ State _______ Zip _______________

Phone __________________ Cell __________________ Work __________________ Ext _________

Email ____

Employer _____________________________________ Occupation ____________________________

If this is your first visit, please complete:

How did you hear about us? ☐ Doctor ☐ Friend ☐ Family Member ☐ Internet ☐ Other __________________

Emergency Contact Information

Name ____ Relationship _______________________

Phone __________________________

Insurance Information

Policy Holder Name __________________________________ Policy Holder DOB ________________

Policy Holder SSN _____________________ Employer ____

Medical Insurance _____________________________________ Member ID ____________________

Vision Plan ____ Member ID ____________________

Date of last eye exam ____________ Dr./Clinic who performed it _______________________________

Date of last medical exam __________________________

Primary Care Physician ____

Do you wear contact lenses: Yes / No Are you interested in contact lenses: Yes / No

Please explaine any difficulties you are having with your eyes _________________________________

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MEDICAL HISTORY QUESTIONNAIRE

Height ____________________ Weight __________________

Current Medications (prescription, over the counter, vitamins, homeopathic):

____

____

Allergies to medications: ____

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Have you ever had any of the following eye procedures: ☐ Lasik ☐ PRK ☐ RK ☐ Cataract Surgery

List **all current & previous** illness, injuries, surgeries:

____

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Please check any of the conditions that you have **today**:

Eyes	☐ Previous Surgery	☐ Contact Lenses	☐ Pain	☐ Double Vision
	☐ Glaucoma	☐ Cataracts	☐ Macular Degeneration	☐Dry Eyes
	☐ Flashes	☐ Floaters		
Ears, Nose, Throat:	☐ Hard Hearing	☐ Ringing in Ears	☐ Vertigo	
Cardiovascular:	☐ Chest Pain	☐ Dizziness	☐ Fainting Spells	
	☐ Shortness of Breath	☐ Irregular Heart Beat	☐ Difficulty Lying Flat	
Constitutional	☐ Fatigue/Weakness	☐ Fever	☐ Weight Gain/Loss	
Respiratory:	☐ Cough	☐ Congestion	☐ Wheezing	☐ Asthma
Gastrointestional:	☐ Heartburn	☐ Nausea/Vomiting	☐ Jaundice/Hepatitis	
Genito-Urinary:	☐ Pain/Difficulty	☐ Blood in Urine	☐ History of Kidney Stones	☐ History of STD's
Psychiatric:	☐ Anxiety/Depression	☐ Mood Swings	☐ Difficulty Sleeping	
Endocrine:	☐ Increased Thirst	☐ Increased Hunger	☐ Increased Urination	
	☐ Increased Sweating	☐ Fingernail Changes		
Blood/Lymphnodes:	☐Prolonged Bleeding	☐ Gums Bleed Easily	☐Heavy Aspirine Use	☐ Easy Bruising
MusculoSkeltal:	☐ Stiffness	☐ Arthritis	☐ Joint Pain/Swelling	
Skin:	☐ Rash/Sores	☐ Lesions	☐ Hives/Eczema	
Neurological:	☐ Seizures	☐ Weakness/Paralysis	☐ Numbness	☐ Tremors
Immunologic:	☐ Hives	☐ Itching	☐ Runny Nose	☐ Sinus Pressure

Do any of your blood relatives have the following conditions:

Blindness	☐ No	☐ Yes	If yes: ☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Glaucoma	☐ No	☐ Yes	If yes: ☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Macular Degeneration	☐ No	☐ Yes	If yes: ☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Diabetes	☐ No	☐ Yes	If yes: ☐ Father	☐ Mother	☐ Sibling	☐ Grandparent
Retinal Detachment	☐ No	☐ Yes	If yes: ☐ Father	☐ Mother	☐ Sibling	☐ Grandparent

Social History:

Do you currently drive?	☐ No	☐ Yes	
Do you currently smoke?	☐ No	☐ Yes	How much? ☐ 1 pack/day or less ☐ 1 pack/day ☐ 2+ packs/day
Have you ever smoked?	☐ No	☐ Yes	When did you quit? ________________
Are you pregnant?	☐ No	☐ Yes	Expected due date? ________________
Are you working?	☐ No	☐ Retired	☐ Yes, occupation? ________________