ADVANCED FAMILY EYE CARE

400 7th Street, Ellwood City
214 W. New Castle St, Zelienople

PATIENT INFORMATION

LAST Name _____

FIRST Name _____ MI_____

Street _____

City _____

State _____ Zip Code _____

Cell Phone _____

Home Phone _____

Patient's SSN _____

Date of Birth _____ Age_____

Sex: Male Female Other

Email Address _____

Spouse/Parent's Name _____

Whom should we notify in case of an emergency?

_____
(name) (telephone) (relationship)

What is the PRIMARY REASON for this visit?
(Circle below all that apply)

Yearly Exam	Foreign Body Sensation
Loss of Vision	Distorted Vision
Loss of Side Vision	Itching Burning
Redness	Floaters
Flashes	Tearing/Watering
Night Glare	Light Sensitivity
Chronic Infection	

Other _____

Any problems with your current contact lenses or glasses? _____

LIFESTYLE QUESTIONS

Do you…(check box if your answer is yes)

- ☐ work at a computer? How much?_____Hrs/day
- ☐ think you might benefit from thinner, lighter lenses?
- ☐ have interest in trying the latest contact lenses?
- ☐ spend time outdoors? How much?_____Hrs/week
- ☐ have prescription sunglasses?
- ☐ prefer not to wear your glasses?
- ☐ want information on Laser Vision Correction surgery?
- ☐ have interest in a non-surgical vision correction?
- ☐ have more than one pair of current Rx eyewear?
- ☐ have children?
- ☐ have family members in need of eyecare?

Whom may we thank for referring you to our office?
Name of friend or relative? _____

If not referred, how did you choose our office?
Another Dr._____
Insurance Company
Saw Sign/Building
Facebook
Google
Other _____

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

I understand that I am responsible for any charges not covered by my medical or vision insurance:

_____
(Signature) Date

MEDICAL HISTORY

List Current Medications:

_____

_____

_____

_____

Allergy Information

Drug Allergies _____

Food/Environmental _____

Primary Care Doctor _____

PCP Phone/Fax _____

PAST OCULAR HISTORY (Circle all that apply)

Cataract Surgery	Lasik
Macular Degeneration	Glaucoma
Retinal Degeneration	Dry Eye
Nystagmus	Injury
Amblyopia	Patching

Eye Surgery _____
Last Eye Exam _____

Do you use eye drops? Yes or No
If so, what type?_____

Do your experience episodes or periods of blurred vision? Yes or No

Do you have problems with your eyes when working on a computer, watching TV or reading? Yes or No

FAMILY HISTORY (check all that apply):

Blindness	_____	Cataracts	_____
Glaucoma	_____	Crossed Eyes	_____
Macular Degeneration	_____	Diabetes	_____
Retinal Detachment	_____	Arthritis	_____
Kidney Disease	_____	Heart Disease	_____
High Blood Pressure	_____	Cancer	_____
Thyroid Disease	_____	Lupus	_____

Other _____

Social History

Are you a smoker? Yes or No
Former Smoker? Yes or No
How long ago?_____

Height _____ Weight _____

Do you currently have, or have you ever had any problems in the following area?
Please Circle

Constitution
Cancer
Fatigue Syndrome
Developmental Disability

Ears, Nose, Mouth, Throat
Hearing Loss
Allergies/Hay Fever
Sinusitis
Dry Mouth

Neurological
Headaches
Migraines
Stroke/CVA
MS
Epilepsy
Seizures
Autism
Tumor
Cerebral Palsy

Psychiatric
Depression
Anxiety
Bipolar
ADHD

Cardiovascular/Vascular
Heart Failure
Vascular Disease
High Blood Pressure
Heart Disease

Respiratory
Smoker
Asthma
COPD
Emphysema
Chronic Bronchitis
Sleep Apnea

Gastrointestinal
Acid Reflux
Crohn's/Colitis
Ulcer
Celiac Disease

Genitourinary
Pregnant
BPH
Prostate Cancer
Kidney Disease
STD

Musculoskeletal
Osteoarthritis
Arthritis
Osteoporosis
Fibromyalgia
Muscular Dystrophy
Ankylosing Spondylitis
Gout

Integumentary
Shingles
Eczema
Cold Sores
Psoriasis
Rosacea

Endocrine
Type 1 Diabetes
Type 2 Diabetes
Thyroid Dysfunction
Hormone Dysfunction

Hematologic/Lymphatic
Anemia
High Cholesterol
Bleeding Problem

Allergic/Immunologic
Rheumatoid Arthritis
Lupus
Sjogren Syndrome