

SUNSET EYECARE PATIENT HISTORY

Last Name: _____ First Name: _____ MI: _____

Address: _____ City/State/Zip: _____

Telephone (H): _____ Cell/Work: _____

SSN: _____ DOB: _____ Age: _____

E-mail address: _____

Occupation: _____ Employer: _____

Marital Status: S M Do you require nursing care: Yes No

Do you have health insurance: Medicare Medicaid Other: _____

Vision Insurance (list provider[s]): _____

How did you learn about our office (check all that apply): Internet Sunset Eyecare.com newspaper ad

radio ad phone book ad referred by doctor referred by friend Other: _____

MEDICAL INFORMATION/REVIEW OF SYSTEMS

How is your general health? (check one) Good Fair Poor

Do you have any health problems? Please list: _____

Are you having any other problems with the following systems? Please check all that apply.

Gastrointestinal Nervous Respiratory Diabetes

Musculoskeletal Mental Integumentary (Skin)

Ears/Nose/Throat Cardiovascular Genitourinary

Allergic/Immunologic Blood/Lymph Endocrine (Hormonal)

Please list **ALL MEDICATIONS**, hormones and birth control: _____

Please list all allergies and drug reactions: _____

Please list all major surgeries, illnesses and the dates they occurred. _____

Do you use cigarettes/tobacco? Yes No Alcohol: Yes No Other: _____

Date of last tetanus shot: _____

FAMILY HISTORY

Diabetes Yes No Relation: _____ Macular Degeneration: Yes No Relation: _____

Glaucoma Yes No Relation: _____ Retinal Detachment: Yes No Relation: _____

Blindness Yes No Relation: _____

PERSONAL EYE INFORMATION

Have you had any eye surgeries? Yes No Please list: _____

Have you had any eye injuries? Yes No Please list: _____

Do you have any known disease of the eye? Yes No Please list: _____

When was your last eye exam? _____ Doctor's Name: _____