Zionsville EYECARE

PATIENT INFORMATION										
First Name:		M.I.:		Last Name:						
Nickname:		DOB:		Marital Status:		Sex:	☐M ☐F			
Address:										
City:		State:		Zip Code:		SSN:				
Home Phone:		Cell Phone:								
Email:										
Occupation/Grade:										
Employer/School:										
Best way to contact you?		How did you hear about us?								

PARENT/LEGAL GUARDIAN/PRIMARY INSURANCE HOLDER INFORMATION					
First Name:		M.I.		Last Name:	
Relationship to Patient:		DOB:		SSN:	
Address:					
City:		State:		Zip Code:	
Home Phone:		Cell Phone:			
Emergency Contact:		Phone:			

PATIENT HISTORY QUESTIONNAIRE					
How would you rate your overall health?					
Do you have problems with any of these systems? (Please check all that apply)					
Gastrointestinal	☐ Y ☐ N	Nervous	☐ Y ☐ N	Blood/Lymph	☐ Y ☐ N
Ears/Nose/Throat	☐ Y ☐ N	Genitourinary	☐ Y ☐ N	Skin	☐ Y ☐ N
Cardiovascular	☐ Y ☐ N	Musculoskeletal	☐ Y ☐ N	Mental	☐ Y ☐ N
Respiratory	☐ Y ☐ N	Endocrine (glands)	☐ Y ☐ N	Allergic/Immune	☐ Y ☐ N
If yes, please explain:					

Please answer all that apply:				
Diabetes? ☐Y ☐N	Type:	Date of Diagnosis:		
Medication Allergy? ☐Y ☐N	Medication name and reaction:			
Other Allergies? ☐Y ☐N	Allergic to what?	Reaction?		
Other health problems:				
Current Medications:				
Do we have your permission to access your medication history with our e-prescribing system? ☐Y ☐N				
Have you had any operations? ☐Y ☐N	Type:	Date:		
Do you use tobacco? ☐Y ☐N	Name of Family Doctor?	Date of last visit?		
FAMILY HISTORY (Relationships)				
High Blood Pressure? ☐Y ☐N	Relation:	Diabetes? ☐Y ☐N	Relation:	
Macular Degeneration? ☐Y ☐N	Relation:	Glaucoma? ☐Y ☐N	Relation:	
Retinal Detachment? ☐Y ☐N	Relation:	Cataracts? ☐Y ☐N	Relation:	
Other eye condition? ☐Y ☐N	What kind?			
PERSONAL EYE INFORMATION				
Have you had any eye operations? ☐Y ☐N	Type:	Date:		
Have you had an eye injury? ☐Y ☐N	Type:	Date:		
Do you have glaucoma? ☐Y ☐N	Cataracts? ☐Y ☐N	Blurred vision? ☐Y ☐N		
Do you wear glasses? ☐Y ☐N	Contact Lenses? ☐Y ☐N	Type:		
Dry Eyes? ☐Y ☐N	Difficulties driving at night? ☐Y ☐N			

RATE YOUR EYE HEALTH SYMPTOMS BELOW:

Symptoms	**Frequency (see scale)**		**Severity (see scale)**	
Dryness, Grittiness or Scratchiness		**0** = Never **1** = Sometimes **2** = Often **3** = Constant		**0** = No Problems **1** = Tolerable **2** = Uncomfortable – irritating **3** = Bothersome – irritating and interferes **4** = Intolerable – Unable to perform daily tasks
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				
Do you use eye drops for lubrication? ☐Y ☐N			If so, how often?	

Select which of the following Age-Related Macular Degeneration risk factors apply to you:			
Female? ☐	Over 50? ☐	Caucasian? ☐	Blue Eyes? ☐
History of Smoking? ☐		Family History of AMD? ☐	