PalmettoEye
& LASER CENTER
Keeping You in Sight

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Please Print

Name: ______________________

Street: ______________________

PO Box: ______________________

City: ____________ State _____ Zip _________

Home #____________ Work #____________

Cell #____________

E-mail Address: ______________________

Employer (or School): ______________________

Occupation (or Grade): ______________________

Medical Primary Insurance Co.: ______________________

Policy #: ______________________

Medical Secondary Ins. Co.: ______________________

Policy #: ______________________

Insured's Social Security: ______________________

Insured's Date of Birth: ______________________

Emergency Contact: ______________________

Today's Date: ______________________

Date of Birth: ____________ Age: _________

Sex: M ☐ F ☐ Social Security #: ____________

Race: Asian African American Caucasian Other
(Circle Choice)

Marital Status: Single Married Separated
Divorced Widowed
(Circle Choice)

Ethnicity: Hispanic or Non Hispanic

Preferred Language: ______________________

Spouse or Parent Name: ______________________

Spouse or Parent Work Phone: ______________________

Please give us your Vision Insurance Information:

Vision Company: ______________________

Vision Policy: ______________________

Your Primary Care Physician: ______________________

Consulting Dr.: ______________________

Nearest Relative Not Living With You: ______________ Relationship: __________ Phone: __________

The following information is very important to your health. Please take the time to fully and accurately complete this form!

Eye History

Check this box if you have NO eye problems or symptoms: ☐ I have no eye problems

Do you have a history of eye problems other than glasses? ☐ Glaucoma ☐ Retinal Disease ☐ Cataract

☐ Other ______________________ ☐ Eye Surgery ______________________

Do you wear contact lenses? ☐Yes ☐No ***If yes, what type and power are your lenses?*** ____________

Do Your Eyes Experience Any of the Following?

- ☐ Burning
- ☐ Sensitivity to Light
- ☐ Excessive Tearing
- ☐ Difficulty Seeing at Night
- ☐ Uncomfortable Glasses
- ☐ Uncomfortable Contact Lenses
- ☐ Double Vision
- ☐ Difficult Reading Small Print
- ☐ Difficult Reading Medium Print
- ☐ Difficult Reading Large Print
- ☐ Problems Seeing to Cook
- ☐ Flashes of Light
- ☐ Floating Objects
- ☐ Blurry Distance Vision
- ☐ Blurry Near Vision
- ☐ Sudden Loss of Vision
- ☐ Glare or Reflection
- ☐ Difficult Night Driving
- ☐ Difficult Seeing Steps/Curbs
- ☐ Difficult Reading Signs
- ☐ Problems Seeing to Play Sports
- ☐ Problems Seeing to Watch TV
- ☐ Strain/Headache
- ☐ Gritty Feeling
- ☐ Itchiness
- ☐ Soreness
- ☐ Redness
- ☐ Dryness
- ☐ Difficult Day Driving
- ☐ Problems Seeing Faces
- ☐ Problems with Fine Handiwork
- ☐ Problems Seeing to Play games
- ☐ Problems filling out forms

What is the MAIN purpose of this visit? What do you want to accomplish by seeing the doctor today?

____

PAYMENT IN FULL IS REQUIRED WHEN SERVICES ARE RENDERED IF THERE IS NO INSURANCE COVERAGE

You will be responsible for any portion of your bill which is not paid for by your insurance company.

(Please continue on back)

Patient Name:_______________________

***Family* Medical History** *Relationship*

Condition	Yes	No	Relationship
Blindness	☐ Yes	☐ No	________
Cataracts	☐ Yes	☐ No	________
Glaucoma	☐ Yes	☐ No	________
Diabetes	☐ Yes	☐ No	________
Hypertension	☐ Yes	☐ No	________
Retinal Disease	☐ Yes	☐ No	________
Stroke	☐ Yes	☐ No	________
Heart Attack	☐ Yes	☐ No	________

Social History

Do you smoke? ☐ Yes ☐ No

If yes, how much per day? ________

Have you ever smoked: ☐ Yes ☐ No

Drink alcohol? ☐ Yes ☐ No

Have you ever had a problem with drug abuse?

☐ Yes (see below) ☐ No

How much? ________

If so, what drug? ________ When? ________

***YOUR* MEDICAL HISTORY**

Medication Allergies: ________________

____

Major Surgeries: ________________

____

Review of Systems: If "YES" List Date of Problem

System	Yes	No	Date
Cardiovascular (Heart)	☐ Yes	☐ No	________
Heart Attack?	☐ Yes	☐ No	________
High Blood Pressure?	☐ Yes	☐ No	________
Vascular Disease?	☐ Yes	☐ No	________
Ear,Nose,Throat,Mouth	☐ Yes	☐ No	________
Endocrine: **Diabetes**	☐ Yes	☐ No	________
Insulin Use	☐ Yes	☐ No	________
Thyroid	☐ Yes	☐ No	________
Hormone	☐ Yes	☐ No	________
Gastrointestinal	☐ Yes	☐ No	________
Ulcer?	☐ Yes	☐ No	________
Reflux?	☐ Yes	☐ No	________
Bleeding?	☐ Yes	☐ No	________
Genitourinary	☐ Yes	☐ No	________
Kidney Stones?	☐ Yes	☐ No	________
Bladder Infections?	☐ Yes	☐ No	________
Immune System	☐ Yes	☐ No	________
Problems with Your Immune System?	☐ Yes	☐ No	________
Hematologic/Lymph	☐ Yes	☐ No	________
Integumentary (Skin)	☐ Yes	☐ No	________
Musculoskeletal	☐ Yes	☐ No	________
Neurological	☐ Yes	☐ No	________
Stroke?	☐ Yes	☐ No	________
Psychiatric	☐ Yes	☐ No	________
Reproductive	☐ Yes	☐ No	________
Are You Pregnant?	☐ Yes	☐ No	________
Are You Breast feeding?	☐ Yes	☐ No	________
Menopause?	☐ Yes	☐ No	________
Prostate Disease?	☐ Yes	☐ No	________
Herpes?	☐ Yes	☐ No	________
Other STD?	☐ Yes	☐ No	________
Respiratory	☐ Yes	☐ No	________
Asthma?	☐ Yes	☐ No	________
COPD?	☐ Yes	☐ No	________
Cancer History?	☐ Yes	☐ No	________
Chemotherapy?	☐ Yes	☐ No	________
Radiation?	☐ Yes	☐ No	________

Type of Cancer? ________________

Medications (including Non-Prescription such as Aspirin, etc.)

Medicine	*Dosage*	*How Often?*

Eye Drops

____

Drug Store: ***Drug Store Phone:***

____

Are you interested in learning about treatment options for any of the following? Please check all that apply.

- ☐ Facial fine lines/wrinkles
- ☐ Drooping brow
- ☐ Drooping eyelids
- ☐ Length/fullness of eyelashes
- ☐ Mole removal around eyes

How concerned are you about the appearance of your wrinkles? Please check only <u>one</u> box below.

- ☐ Not concerned
- ☐ Somewhat concerned
- ☐ Very concerned