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

| | | | |
|---|---|---|---|
| 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**

| | | | |
|---|---|---|---|
| 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