Lewis County
Eye & Vision Associates, P.S.

Today's Date_____

Please Print

Patient Last Name: _____ First Name _____ Middle Initial:___ Nickname:_____

Date of Birth: _____/_____/_____ Age: _____ ☐Male ☐Female

Mailing Address:_____City:_____State:_____Zip:_____

Employed? Yes No If so, who is your current employer? _____
Occupation? _____

SSN: _____-_____-_____ Marital Status: _____

FT/PT Student? Yes No If so, name of school? _____

Preferred Contact Method(email/text/call): _____ Email Address:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Would you like to be contacted for specials and promotions? ☐ Yes ☐ No

Emergency Contact Name:_____ Emergency Contact Phone #_____

Insurance Information:

Primary **Vision** Insurance Name:_____ ID #_____Group #_____
Policy Holder Name:_____ DOB:_____
Employer:_____ Relationship to Patient:_____

Secondary **Vision** Insurance Name:_____ ID#_____ Group #_____
Policy Holder Name:_____ DOB:_____ Employer:_____

Primary **Medical** Insurance Name:_____ ID#_____ Group #_____
Policy Holder Name:_____ DOB:_____
Employer:_____ Relationship to Patient:_____

Secondary **Medical** Insurance Name:_____ ID#_____ Group #_____
Policy Holder Name:_____ DOB:_____ Employer:_____

If patient is under the age of 18, please write social security number of parent/guardian_____-_____-_____

Please see other side

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Other Information:

Preferred Language: _____ Race: _____ Ethnicity (Hispanic/Non-Hispanic): _____

Height: _____ Weight: _____

Date of last Eye Exam: _____/_____/_____ Doctor's name (If not here): _____

Primary Care Physician: _____ Last visit: _____/_____/_____

Are you Pregnant: ☐ Yes ☐ No If so, are you nursing: ☐ Yes ☐ No

Contact Lens Information:

Are you interested in contact lenses? ☐ Yes ☐ No Have you ever worn contact lenses? ☐ Yes ☐ No

Contact Lens Wearers (ONLY):

Are your lenses comfortable? ☐ Yes ☐ No Current Brand: _____

What solution do you use? _____ How often do you replace your contacts? _____

How old is your current Pair? _____ Do you sleep in your contacts? ☐ Yes ☐ No

Average wear time per day? _____

Social History:

This information is required by insurance carriers and is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. If so, check here. ☐

Do you currently use tobacco products? ☐ Yes ☐ No

Type (i.e. cigarettes, chew, etc.) _____ How often? _____

If you have stopped smoking, please indicate when. _____

Do you drink Alcohol? ☐ Yes ☐ No If yes, how often? _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, how often? _____

Do you have any of the following?:

Tuberculosis (TB):	☐ Yes	☐ No	Herpes:	☐ Yes	☐ No	Syphilis:	☐ Yes	☐ No
Chlamydia:	☐ Yes	☐ No	HIV:	☐ Yes	☐ No	Hep C	☐ Yes	☐ No

Please see other side

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What is the main reason for your visit today? _____

_____

Medical History/ Review of Systems

Please circle yes or no to the following questions:

Do you currently have any problems in the following areas?

EYES

Blurred Vision ☐ Yes ☐ No
Blindness ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Foreign body sensation ☐ Yes ☐ No
Burning ☐ Yes ☐ No
Eye Turn ☐ Yes ☐ No
Itching eyes ☐ Yes ☐ No
Dry eyes ☐ Yes ☐ No
Lazy Eye ☐ Yes ☐ No
Sensitive to light ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Patching ☐ Yes ☐ No
Halos around light ☐ Yes ☐ No
Tired or hurt eyes ☐ Yes ☐ No
Macular Degeneration ☐ Yes ☐ No
Eyes feel sandy/gritty ☐ Yes ☐ No
Flashes of light ☐ Yes ☐ No
Retinal Detachment ☐ Yes ☐ No
Floaters ☐ Yes ☐ No
Eye Surgery ☐ Yes ☐ No

If so, What kind? _____

_____

Date of Surgery_____

Other_____

HEMATOLOGIC/LYMPHATIC

Anemia ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
Bleeding Problems ☐ Yes ☐ No
Other_____

GENITOURINARY

Genital/Kidney/Bladder ☐ Yes ☐ No
Other_____

ENDOCRINE

Thyroid Problems ☐ Yes ☐ No
Diabetes (Type 1, Type 2) ☐ Yes ☐ No
Bleeding Problems ☐ Yes ☐ No
Other_____

CARDIOVASCULAR

Heart Disease ☐ Yes ☐ No
High blood pressure ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Vascular Disease ☐ Yes ☐ No
High Cholesterol ☐ Yes ☐ No
Other_____

GASTROINTESTINAL

Crohn's ☐ Yes ☐ No
Colitis ☐ Yes ☐ No
Ulcer ☐ Yes ☐ No
Other_____

MUSCULOSKELETAL

Arthritis ☐ Yes ☐ No
Fibromyalgia ☐ Yes ☐ No
Muscular Dystrophy ☐ Yes ☐ No
Other_____

NEUROLOGICAL

Migraines ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Multiple Sclerosis ☐ Yes ☐ No
Other_____

ALLERGIC/IMMUNOLOGIC

Drug Allergy? ☐ Yes ☐ No
If so, please see medication list (Page4)
Environmental Allergy ☐ Yes ☐ No
Lupus ☐ Yes ☐ No
Other_____

RESPIRATORY

Asthma ☐ Yes ☐ No
Bronchitis ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Other_____

PSYCHIATRIC

Depression ☐ Yes ☐ No
Panic Disorder ☐ Yes ☐ No
Schizophrenia ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Other_____

Please see other side

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Family History

Family history is unknown/adopted ☐

Lazy Eye (Amblyopia)	☐ Yes	☐ No	Relationship to Patient: _____
Glaucoma	☐ Yes	☐ No	Relationship to Patient: _____
Cataracts	☐ Yes	☐ No	Relationship to Patient: _____
Retinal Detachment/Disease	☐ Yes	☐ No	Relationship to Patient: _____
Macular Degeneration	☐ Yes	☐ No	Relationship to Patient: _____
Diabetes	☐ Yes	☐ No	Relationship to Patient: _____
High Blood Pressure	☐ Yes	☐ No	Relationship to Patient: _____

List of Your Current Medication(s) *AND* Reason:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Medication Allergies:

1._____ 2. _____
3._____ 4. _____
5._____ 6. _____

I agree that the preceding information is correct to the best of my knowledge.

Signature:_____ Date:_____

Have there been any changes to your medical history since your last visit? (I.e., surgeries, medical conditions)

☐ Yes ☐ No Signature:_____ Date:_____ Doctor's Signature:_____
☐ Yes ☐ No Signature:_____ Date:_____ Doctor's Signature:_____
☐ Yes ☐ No Signature:_____ Date:_____ Doctor's Signature:_____
☐ Yes ☐ No Signature:_____ Date:_____ Doctor's Signature:_____
☐ Yes ☐ No Signature:_____ Date:_____ Doctor's Signature:_____

Please see other side