

M EYE CENTER OF MURPHY

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PATIENT'S NAME _____ DATE _____

GENDER (circle one) *M* *F* RACE (circle one) *WHITE* *AFRICAN-AMERICAN* *HISPANIC* *ASIAN* *AMERICAN INDIAN* *OTHER*

MARITAL STATUS (circle one) *MARRIED* *SINGLE* *DIVORCED* *WIDOWED* *LEGALLY SEPARATED*

ETHNICITY (circle one) *HISPANIC OR LATINO* *NATIVE HAWAIIAN/ OTHER PACIFIC ISLAND* *NOT HISPANIC/LATINO*

PREFERRED LANGUAGE _____ APPROXIMATE HEIGHT _____ APPROXIMATE WEIGHT _____ lbs

PATIENT'S BIRTHDATE _____ PARENT OR GUARDIAN (if a minor) _____

MAILING ADDRESS _____ CITY _____ STATE _____

ZIP _____ HOME PHONE# _____ CELL PHONE # _____

PREFERRED METHOD OF COMMUNICATION (circle one) *PHONE* *EMAIL* *LETTER* PREFERRED DAYTIME PHONE# *HOME* *CELL PHONE* *OTHER*

EMAIL _____ SS# (if using insurance) _____

OCCUPATION _____ EMPLOYER OR SCHOOL _____ GRADE _____

INSURED MEMBER'S NAME & DATE OF BIRTH _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

MY VISIT TODAY IS FOR (circle one): *GLASSES* *CONTACT LENSES* *LASER VISION CORRECTION* *OFFICE VISIT*

OTHER (please explain) _____ DATE OF LAST EYE EXAM _____ DOCTOR _____

MEDICAL HISTORY: ARE YOU PREGNANT AND/OR NURSING AT THIS TIME? YES NO TOBACCO USE ? *PREVIOUS* *NEVER* *CURRENT*

LIST ALL MEDICAL CONDITIONS: _____

LIST ALL MEDICATIONS (including eye drops and over-the-counter) YOU ARE CURRENTLY TAKING: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO LIST _____

EYE HISTORY: EYE INJURIES (foreign objects, black eye, etc.) YES NO

EYE DISEASE YES NO EYE SURGERY (cataract, laser vision correction, etc.) YES NO

IF YES TO ANY ABOVE, PLEASE TELL WHAT AND WHEN: _____

DO YOU WEAR CONTACTS? YES NO IF SO, TYPE _____

* ADDITIONAL INFORMATION ON SECOND PAGE

EYES (Ocular symptoms)

Eye pain or soreness	YES	NO
Fatigue / tired eyes	YES	NO
Dry / Gritty feeling	YES	NO
Redness	YES	NO
Burning	YES	NO
Itching	YES	NO
Excess watering	YES	NO
Mucous discharge	YES	NO
Chronic infections	YES	NO
Squinting	YES	NO
Glare / light sensitivity	YES	NO
Halos around lights	YES	NO
Double vision	YES	NO
Loss of vision	YES	NO
Blurred vision	YES	NO
Flashes	YES	NO
Floaters	YES	NO

CONSTITUTIONAL

Fever	YES	NO
Weight loss or gain	YES	NO

SKIN

Rosacea (adult acne)	YES	NO
Metal allergies	YES	NO

EAR, NOSE, THROAT, MOUTH

Allergies / Hay fever	YES	NO
Sinus infections	YES	NO
Hearing loss	YES	NO

RESPIRATORY

Asthma	YES	NO
Chronic bronchitis	YES	NO
Emphysema	YES	NO

VASCULAR / CARDIOVASCULAR

Heart disease	YES	NO
High blood pressure	YES	NO
High cholesterol	YES	NO
Stroke	YES	NO

GASTROINTESTINAL

Acid reflux	YES	NO
Intestinal problems	YES	NO
Liver / spleen	YES	NO

ENDOCRINE

Thyroid / other glands	YES	NO
Diabetes	YES	NO

GENITOURINARY

Genitals/kidney/bladder	YES	NO
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LYMPHATIC/HEMATOLOGIC

Anemia	YES	NO
Bleeding	YES	NO

BONES/JOINTS/MUSCLES

Rheumatoid arthritis	YES	NO
Muscle/joint pain	YES	NO

NEUROLOGICAL

Headaches	YES	NO
Seizures	YES	NO
Alzheimer's	YES	NO
Parkinson's	YES	NO

PSYCHIATRIC

Depression	YES	NO
Anxiety	YES	NO
Other	YES	NO

IMMUNE SYSTEM

	YES	NO
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FAMILY HISTORY

Glaucoma	YES	NO
Macular Degeneration	YES	NO
Cataracts	YES	NO
Retinal Detachment	YES	NO
Diabetes	YES	NO
Heart Disease	YES	NO

NOTES _____

Patient Name _____

Date _____