PATIENT FORM

STOUGHTON
EYE CARE & EYEWEAR

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

How did you hear about us

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

STOUGHTON
EYE CARE & EYEWEAR

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

			Relationship
Cataracts	*yes*	*no*	*family -*
Crossed Eye	*yes*	*no*	*family -*
Glaucoma	*yes*	*no*	*family -*
LASIK or RK	*yes*	*no*	*family -*
Lazy Eye	*yes*	*no*	*family -*
Macular Degeneration	*yes*	*no*	*family -*
Retinal Detachment	*yes*	*no*	*family -*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

			Relationship
AIDS/HIV	*yes*	*no*	*family -*
Allergies	*yes*	*no*	*family -*
Arthritis	*yes*	*no*	*family -*
Asthma	*yes*	*no*	*family -*
Blood/Lymph Disorder	*yes*	*no*	*family -*
Cancer	*yes*	*no*	*family -*
Diabetes	*yes*	*no*	*family -*
Ears, Nose, Throat Conditions	*yes*	*no*	*family -*
Gastrointestinal Conditions	*yes*	*no*	*family -*
Heart Disease	*yes*	*no*	*family -*
High Blood Pressure	*yes*	*no*	*family -*
High Cholesterol	*yes*	*no*	*family -*
Kidney Disease	*yes*	*no*	*family -*
Lupus	*yes*	*no*	*family -*
Neurological Conditions	*yes*	*no*	*family -*
Psychiatric Disorder	*yes*	*no*	*family -*
Seizures	*yes*	*no*	*family -*
Skin Conditions	*yes*	*no*	*family -*
Stroke	*yes*	*no*	*family -*
Thyroid Dysfunction	*yes*	*no*	*family -*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

Alcohol Use/How often?