Patient Intake Form

First Name:_____ **Last name:**_____ **MI:**____ **Nickname:**_____

Date of Birth:_____/_____/_____ **Sex:**_____ **SSN:**__ _____-_____-_____

Address:_____**Apt/Suite #:**_____

City:_____**State:**_____**Zip Code:**_____

Cell Phone:_____**Home Phone:**_____

Email:_____

Please Circle Preferred Contact: Cell Home Email Text

Occupation:_____**Employer Name:**_____

Please Circle Marital Status: Married Single Divorced Widowed

Race:

- ☐ Caucasian
- ☐ Hispanic
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____

Eye History

What is the main reason for your visit today?_____

Do you currently have any of these symptoms?

- ☐ None
- ☐ Eye strain or tired eyes
- ☐ Poor night vision/glare
- ☐ Dry eyes
- ☐ Floaters
- ☐ Frequent headaches
- ☐ Light sensitivity
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Watery eyes
- ☐ Burning or stinging eyes
- ☐ Eye pain or tenderness
- ☐ Double vision
- ☐ Flashes of light or blackouts
- ☐ Other:_____

Do you currently take any eye medications? Yes or No

If yes, please list:_____

Please list any eye surgeries and/or trauma including dates:

_____

When was your Last Eye Exam:

- ☐ Less than 1 year
- ☐ 1 year
- ☐ 2 years
- ☐ 3 years or more

What is your Primary Vision Correction?

- ☐ None
- ☐ Glasses; How old?_____
- ☐ Soft contact lenses;
  Brand:_____
  Power:_____
- ☐ Hard contact lenses;
  Brand:_____
- ☐ Other:_____

Medical History

COVID-19 Screening

Do you have any of the following: fever or chills, cough, shortness of breath or difficulty breathing, sore throat, body aches, or new loss of taste or smell?

- ☐ Yes
- ☐ No

Have you been in close contact (within 6 feet) with someone who has a laboratory confirmed COVID-19 diagnosis in the past 14 days?

- ☐ Yes
- ☐ No

Do you have any of these medical conditions?

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Cataract
- ☐ Lazy/Crossed Eye
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Thyroid Conditions
- ☐ Heart Conditions
- ☐ Cancer; Type _____
- ☐ Other:_____

Do you take any medications?

- ☐ Yes; Please list:_____
- ☐ No

Do you have any drug allergies?

- ☐ Yes; Please List:_____
- ☐ No/Unknown

Have you had any surgeries?

- ☐ Yes; Please List& When:_____
- ☐ No

When was your last Primary Care Visit?_____

Are you Pregnant or Nursing?

- ☐ Yes, pregnant
- ☐ Yes, nursing
- ☐ No
- ☐ Unsure

Family Medical History

Does anyone in your family have any of these medical conditions?

- ☐ Macular Degeneration
  Relation:_____
- ☐ Glaucoma
  Relation:_____
- ☐ Retinal Detachment
  Relation:_____
- ☐ Blindness
  Relation:_____
- ☐ Cataract
  Relation:_____
- ☐ Lazy/Crossed Eye
  Relation:_____
- ☐ Diabetes
  Relation:_____
- ☐ High Blood Pressure
  Relation:_____
- ☐ High Cholesterol
  Relation:_____
- ☐ Thyroid Conditions
  Relation:_____
- ☐ Heart Conditions
  Relation:_____
- ☐ Cancer
  Relation:_____
- ☐ Other:_____
  Relation:_____

Review Of Systems

Do you have any of the following conditions?:

General

- ☐ None
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Developmental Disorders
- ☐ Other_____

Skin

- ☐ None
- ☐ Acne
- ☐ Lupus
- ☐ Dermatitis
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Skin Cancer
- ☐ Itching
- ☐ Other_____

Ear/Nose/Throat

- ☐ None
- ☐ Sinus Problems
- ☐ Sore Throat (Recent)
- ☐ Headache
- ☐ Morning Headaches
- ☐ Migraine Headache
- ☐ Cluster Headache
- ☐ Hearing Loss
- ☐ Tinnitus
- ☐ Congestion
- ☐ Dry throat / mouth
- ☐ Sleep Apnea
- ☐ Other _____

Respiratory

- ☐ None
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Sarcoidosis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other_____

Musculoskeletal

- ☐ None
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Muscular Dystrophy
- ☐ Lupus
- ☐ Decreased range of motion
- ☐ Pain/tenderness
- ☐ Stiffness
- ☐ Swelling
- ☐ Weakness
- ☐ Other_____

Psychiatric

- ☐ None
- ☐ Attention Deficit Disorder
- ☐ Anxiety
- ☐ Brain Damage (trauma)
- ☐ Panic Attacks
- ☐ Alzheimer's Disease
- ☐ Bipolar
- ☐ Depression
- ☐ Insomnia
- ☐ Obsessive/Compulsive
- ☐ Paranoia
- ☐ Other_____

Endocrine

- ☐ None
- ☐ Crohn's disease
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diabetes Suspect/Pre
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Gout
- ☐ Hormone Replacement
- ☐ Other

Blood/Lymph

- ☐ None
- ☐ Anemia
- ☐ Hematologic Disorder
- ☐ Sickle Cell Disorder
- ☐ Lymph Node Disease
- ☐ Temporal Arthritis
- ☐ Cuts slow to clot
- ☐ Easy bruising
- ☐ Other

Neurological

- ☐ None
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder
- ☐ Parkinson's Disease
- ☐ Brain Tumor
- ☐ Bell's Palsy
- ☐ Dyslexia
- ☐ Headache
- ☐ Balance problems
- ☐ Vertigo
- ☐ Tremors
- ☐ Dementia
- ☐ Muscle weakness
- ☐ Speech problems
- ☐ Other

Immune

- ☐ None
- ☐ Seasonal allergies
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Sjogren's syndrome
- ☐ HIV Simplex
- ☐ Mononucleosis
- ☐ Tuberculosis
- ☐ Cytomegalovirus Infection
- ☐ Herpes Zoster
- ☐ Lyme Disease
- ☐ Sarcoidosis
- ☐ Syphilis
- ☐ Hives
- ☐ Mild allergy symptoms
- ☐ Severe allergy symptoms
- ☐ Other

STDs

- ☐ None
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Hepatitis
- ☐ HIV/AIDS

Genitourinary

- ☐ None
- ☐ Amenorrhea
- ☐ Menopause
- ☐ Impotence
- ☐ Jaundice
- ☐ Uterine Cancer
- ☐ Prostate Cancer
- ☐ Kidney Stones
- ☐ Syphilis
- ☐ Prostate Problems
- ☐ Bladder Infections
- ☐ Other

Gastrointestinal

- ☐ None
- ☐ Acid Reflux
- ☐ Crohn's disease
- ☐ Gastric reflux (GERD)
- ☐ IBS
- ☐ Ulcer
- ☐ Gallbladder problems
- ☐ Hepatitis
- ☐ Sarcoidosis
- ☐ Other

Cardiovascular

- ☐ None
- ☐ Congestive Heart Disease Cardiovascular Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Arrhythmia
- ☐ Heart Murmur
- ☐ Heart Palpitation
- ☐ Chest Pain
- ☐ Arteriosclerosis
- ☐ Coagulation Disorder
- ☐ Mitral Valve Prolapse
- ☐ Low Blood Pressure
- ☐ Other

Smoking Status

- ☐ Never smoker(Less than 100 cigs equiv)
- ☐ Former smoker (no longer smokes)
- ☐ Current some days smoker (not daily)
- ☐ Light smoker(Greater than 10cigs/day)
- ☐ Heavy smoker (More than 10 cigs/day)
- ☐ Smoker (current status unknown)

Type

- ☐ None
- ☐ Cigarettes
- ☐ Chewing Tobacco
- ☐ E-Cigarettes
- ☐ Marijuana
- ☐ Other:_____

How long have you been smoking?:_____

Drinking Status

- ☐ Never
- ☐ Seldom (Few time a year or less)
- ☐ Occasionally/ Socially (1-2 times a month)
- ☐ Often (3-4 times a week)
- ☐ Daily

Billing Information

Is The Billing Address Different? Yes No

If yes, please provide the billing address information below:

_____

Primary Vision Insurance

Insurance Name:_____ **Insurance Plan:**_____

Insurance ID:_____ **Insurance Policy Group:**_____

If not primary, Please fill in the following information:

Primary Name:_____ Date of Birth:_____/_____/_____

SSN:_____-_____-_____ Address:_____ Phone:_____

Primary Medical Insurance

Insurance Name:_____ **Insurance Plan:**_____

Insurance ID:_____ **Insurance Policy Group:**_____

If not primary, Please fill in the following information:

Primary Name:_____ Date of Birth:_____/_____/_____

SSN:_____-_____-_____ Address:_____ Phone:_____