COLONIAL RIVER EYE CARE

Patient Health/Welcome Form

Patient Name: _____DOB____ /____ /____ Email: _____
Address:_____ City: _____State:_____ Zip :_____Phone #:_____
Preferred Name/Nickname: _____Patient Occupation/Grade:_____ Cell #:_____
Primary Care Physician: _____ Parents (If a minor): _____ Gender: M / F

What is the main reason for your visit today?_____ _____ **Do you wear:** ☐Contacts ☐Eyeglasses
Are you interested in contacts? ☐ Yes ☐ No

If you wear contacts, please fill out this section:
How many hours per day do you wear contacts?_____ How often do you replace your contacts?_____
What brand do you wear?_____ Describe any problems with your Contacts: _____
_____

Medical/Family History

Please list current medications:_____
_____
List any **allergic** reactions to medications or eye drops? What is the reaction?_____
Women – Are you pregnant or nursing? ☐ Yes ☐ No
If you are a new patient, When was your last eye exam?_____ Doctor:_____

Do you have any of the following symptoms: ☐ No

☐ Blurry vision	☐ Double vision	☐ Watering eyes	☐ Eye strain	☐ Discharge from eyes
☐ Bloodshot Eyes	☐ Dry eyes	☐ Poor color vision	☐ Burning eyes	☐ Temporary vision loss
☐ Seeing spots or floaters	☐ Flashes	☐ Poor night vision	☐ Itching eyes	☐ Seeing haloes

Please indicate if any of the conditions apply:

Disease/Condition	**Yourself** Yes	No		**Family Member** Yes	NO	**Relationship (Blood Relatives Only)**
Cataract	☐	☐	Blindness	☐	☐	_____
Eye Turn	☐	☐	Eye Turn	☐	☐	_____
Glaucoma	☐	☐	Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	Retinal Detachment	☐	☐	_____
Other	☐	☐				
Eye Surgery	☐	☐	Date of surgery: _____	by What Dr:_____		

Are you **Diabetic**? Yes / No If so, what year were you diagnosed? _____ What was your blood sugar today? _____
What is your most current HbA1C? _____ How do you control it? ☐ Diet ☐ Medication ☐ Insulin
Social: Tobacco use: ☐ Current Smoker ☐ Former Smoker ☐ Non Smoker ☐Current Smokeless Tobacco User Packs per day _____
Do you use: Non-prescription drugs ☐ yes ☐ No Do you consume Alcohol? ☐ yes ☐ No

Do you have or have you had any of the following? (check all that apply): ☐ No, I do not have or had any of the diseases listed below

☐ AIDS/HIV	☐High Blood Pressure	☐ Carotid Artery Disease	☐ Rheumatoid Arthritis
☐ High Cholesterol	☐ Thyroid Disease	☐ Asthma	☐ Kidney Disease
☐Tuberculosis	☐ Emphysema	☐ Lupus	☐ Sarcoid
☐Chemical dependency	☐ Crohn's Disease	☐ Multiple Sclerosis (MS)	☐ Hay fever/Allergies
☐ Colitis	☐ Migraines	☐ Heart Disease	☐ Rosacea
☐ Hepatitis	☐ Stroke	☐ Cancer: Where? _____	☐ Other _____

Lifestyle Information: To help us assist you with your eye care needs, please check all that apply:
☐Boating/Fishing ☐Shooting ☐ Golfing ☐ Motorcycling ☐Bicycling ☐Participate in sports ☐Swimming ☐Driving ☐ Hunting ☐ Reading
☐Woodworking ☐Use of power tools ☐Gardening ☐Hiking ☐Close-up work ☐Intermediate work Computer usage (hours a day _____)

Please sign to acknowledge this form's information is current and you that had the opportunity to read/take our financial policy.

Patient's signature or legal guardian: _____ **Date:** _____
(Must be 18 years of age)