

**Deadwood Eyecare**

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DATE \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Spouse or parent \_\_\_\_\_ Spouses place of employment \_\_\_\_\_

Name of last eye Dr. and date of last exam \_\_\_\_\_

Referred BY? \_\_\_\_\_ Patient Email Address \_\_\_\_\_

**MEDICAL INFORMATION**

**Do you or have you ever had any of the following?**

Y N Ears/nose/mouth/throat problems \_\_\_\_\_

Y N Constitutional (Fever/Unexplained weight loss/gain) \_\_\_\_\_

Y N Cardiovascular (Heart Disease etc) \_\_\_\_\_

Y N Respiratory Disease (ex COPD) \_\_\_\_\_

Y N Tuberculosis \_\_\_\_\_

Y N Gastrointestinal disease (ex Crohn's) \_\_\_\_\_

Y N Genitourinary disease (ex Kidney Disease) \_\_\_\_\_

Y N Arthritis (specify type) \_\_\_\_\_

Y N Muscle Pain \_\_\_\_\_

Y N Skin Conditions \_\_\_\_\_

Y N Headaches \_\_\_\_\_

Y N Other Neurologic problems (MS etc.) \_\_\_\_\_

Y N Psychiatric \_\_\_\_\_

Y N Endocrine disease (Thyroid etc.) \_\_\_\_\_

Y N Diabetes Type \_\_\_\_\_

Y N Hematologic/lymphatic (ex Blood Disease) \_\_\_\_\_

Y N Hepatitis A/B/C \_\_\_\_\_

Y N Have you ever tested positive to HIV or other Infectious Disease  
(please specify) \_\_\_\_\_

Y N Allergic/Immunologic \_\_\_\_\_

Y N Cancer (specify type below) \_\_\_\_\_

Y N Watery/red/itchy eyes

Y N Double Vision

Y N Dry Eyes

Y N Amblyopia (Lazy eye)

Y N Floaters/spots

Y N Strabismus (Eye turn )

Y N Flashes of light

**PERSONAL INFORMATION**

Are you pregnant or nursing? Y N

Weight \_\_\_\_\_ LB

Ethnicity: Hisp/Lat Not-Hisp/Lat Decline

Height \_\_\_\_\_ FT \_\_\_\_\_ IN

Race: Afr-Am Cauc Asian Hisp Am- Ind Decline

Any other medical problems not listed above:

Do you have any medication allergies... If YES what type of reaction

Yes/No \_\_\_\_\_

Are you taking any medications Y N Please list:

Have you had any operations \_\_\_\_\_

Name of family doctor \_\_\_\_\_

Date of last visit \_\_\_\_\_

**Social History**

Are you a: Current smoker \_\_\_ b: Never smoker \_\_\_ C: Previous smoker \_\_\_ (If you have habitually smoked, How many years? \_\_\_\_\_)

Do you drink alcohol Yes/No How much \_\_\_\_\_

Do you use any other drugs Yes/No \_\_\_\_\_

**FAMILY HISTORY (list any family members who may have the following)**

Macular Degeneration Yes/No Relation \_\_\_\_\_

Diabetes Yes/No Relation \_\_\_\_\_

Glaucoma Yes/No Relation \_\_\_\_\_

Heart Disease Yes/No Relation \_\_\_\_\_

Autoimmune Disease Yes/No Relation \_\_\_\_\_

Thyroid Disease Yes/No Relation \_\_\_\_\_

Other genetic disease Yes/No \_\_\_\_\_

**PERSONAL EYE INFORMATION**

Eye conditions or problems Yes/No \_\_\_\_\_

Eye Operations Yes/No \_\_\_\_\_

Date \_\_\_\_\_

Eye Injuries Yes/No \_\_\_\_\_

Date \_\_\_\_\_

Glaucoma Yes/No \_\_\_\_\_

Cataracts

Yes/No

Macular Degeneration Yes/No \_\_\_\_\_

Retinal Detachments

Yes/No

**Signature on file:**

I authorize release of relevant medical information to the following person(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I acknowledge that a copy of the Notice of Privacy Practices for Deadwood Eyecare was made available to me and I authorize the release of information to my insurance companies. **I understand that I am responsible for any amount not covered by my insurance**

Sign \_\_\_\_\_ Date \_\_\_\_\_