ANNE ARUNDEL FAMILY EYE CARE

Date:_____

PATIENT HISTORY

Name: Dr/Mr/Mrs/Ms_____
(FIRST) (MI) (LAST)
Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Email:_____ DOB:_____
Responsible Party:_____ SSN:_____
Insurance:_____
Patient Occupation:_____ Employer:_____
Last Eye Exam Date:_____ with Dr:_____
Whom may we thank for referring you?_____
What is your main reason for coming today?_____
_____

This is your opportunity to tell us about all areas in which your vision is not serving you well:
Are there times when your vision (or present lens) isn't quite right?_____
_____
Are there any activities you would enjoy doing, but must restrict because of your vision?_____
_____
Have you ever worn glasses? Y/N Do you wear glasses now? Y/N
If yes, **O** for distance only **O** for near only **O** wear them full time **O** for computer monitor **O** sports
Do you wear contacts at this time? Y/N What type:_____
Have you had problems wearing contacts? Y/N Describe:_____
Have you been told you cannot wear them? Y/N Are you interested in trying contacts? Y/N
Are you interested in Refractive Surgery (Lasik)? Y/N
Do you use a computer on your job? Y/N # of hours daily_____
Do you use a computer at home? Y/N # of hours daily_____
What lenses do you wear? **O** none **O** glasses **O** bifocals **O** contacts
When computing, do your eyes get: **O** red **O** dry **O** sore
Do letters ever seem to swim? Y/N Does office lighting bother you? Y/N
Do reflections and glare bother you? Y/N Is it hard to proofread, or find errors? Y/N

Do you experience any of the following discomforts at work or at home?
O headaches **O** eyestrain **O** get sleepy **O** letters blur as your read **O** eyes red or watery
O lose your place often **O** occasionally see double **O** pulling sensation near eyes
O do you avoid certain tasks
Does it take more and more effort to see clearly as the day wears on? Y/N
Do you avoid reading after work, but read on weekends? Y/N How long can you read?_____
Do you "hunch" closer to your work as the day wears on? Y/N
Do street signs ever seem blurred as you drive home from work? Y/N
Is it ever difficult to bring print or objects into clear focus? Y/N When?_____

Recreation and Leisure

In what recreational activities do you participate? (check all that apply): **O** read **O** racquetball **O** tennis **O** golf **O** baseball **O** basketball **O** swim **O** boating **O** sew **O** play cards **O** flying **O** lacrosse **O** musical instrument Other recreational activities:_____

Do you wear any special or protective eyewear for your sport? Y/N

Does your vision, or do your lenses, interfere with any activity? Y/N

What are you doing to protect your eyes from ultraviolet exposure?_____

Do you currently wear glasses that have an anti-reflective coating? Y/N

Television: Is your viewing ever uncomfortable? Describe:_____

Do you recline while viewing? Y/N Do your lenses work for TV? Y/N

Do you play video games? Y/N # hrs:_____

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies:	**O** self	**O** family	Thyroid:	**O** self	**O** family	Dry Eyes:	**O** self	**O** family
Respiratory disease:	**O** self	**O** family	Migraine or headaches:	**O** self	**O** family	Floaters / spots:	**O** self	**O** family
Cancer:	**O** self	**O** family	Head trauma:	**O** self	**O** family	Flashing lights:	**O** self	**O** family
Diabetes:	**O** self	**O** family	Lazy eye:	**O** self	**O** family	Retinal detachments:	**O** self	**O** family
Drug sensitive:	**O** self	**O** family	Turned eye:	**O** self	**O** family	Blindness:	**O** self	**O** family
Elevated cholesterol:	**O** self	**O** family	Color "blind":	**O** self	**O** family	Cataracts:	**O** self	**O** family
Heart problem:	**O** self	**O** family	Light sensitive:	**O** self	**O** family	Glaucoma:	**O** self	**O** family
High blood pressure:	**O** self	**O** family	Macular Degeneration:	**O** self	**O** family	Eye surgery or injury:	**O** self	**O** family

Are you presently taking any medications? Y/N If so, please list and state for what purpose:_____

Are you allergic to any medications: Y/N If so, please list:_____

Name of family doctor:_____ Date of last exam:_____

INSURANCE INFORMATION

VISION INSURANCE PLAN Patient's relationship to insured: **O** self **O** spouse **O** child **O** other

Name of Vision Plan:_____ Insured Name:_____ Insured DOB:_____

Member ID:_____ Group Number:_____ Policy Number:_____

Claims Address:_____ Claims Phone Number:_____

MAJOR MEDICAL INSURANCE Patient's relationship to insured: **O** self **O** spouse **O** child **O** other

Name of Plan:_____ Insured Name:_____ Insured DOB:_____

Member ID:_____ Group Number:_____ Policy Number:_____

Claims Address:_____ Claims Phone Number:_____

Signature:_____ Date:_____ Dr's initials/Date:_____