NEW PATIENT INFORMATION

Patient Name_____ Middle Initial_____ Cell Phone_____
Address: _____ Birth Date: _____
City: _____ State: ____ Zip code: _____ Gender: Male - Female (circle)
Home Phone: _____ Race/Ethnicity: _____
Work Phone: _____ Language Preference_____
Email: _____
Do you prefer to be reminded that you are due for your next eye exam by: Mail - Phone – Email (circle)?

❑ Single ❑ Married ❑ Employed ❑ **Right handed** ❑ **Left handed** ❑ Part-Time Student ❑ Full-Time Student

Employer: _____ Position: _____ School Name: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Home Phone: _____
Relationship to patient: _____ Work Phone: _____

RESPONSIBLE PARTY (INSURANCE)

Name: _____ Birth Date: _____
Address: _____ Phone: _____

VISUAL AND MEDICAL HISTORY

Date of last eye exam: _____ By Whom? _____
Do you presently wear: Eyeglasses - Contacts - Both - Neither (circle)?
How old are your glasses? _____
What brand of contact lenses? _____
Are your contacts comfortable? Yes - No (circle) How old are your contacts? _____
Name of Medical doctor: _____ Phone: _____
List all your current medications with dosage and usage (include oral contraceptives, aspirin, otc and or herbal meds.)
_____
_____
Do you have allergies to any medications? Yes - No (circle) If yes please list & specify reaction: _____
_____
_____
List all surgeries and/or hospitalizations you have had: _____
_____
Check any of the following you have had:

❑ Crossed Eyes ❑ Retinal Disease ❑ Eye Pain ❑ Floaters ❑ Lazy Eye ❑ Cataracts ❑ Itching ❑ Flashes ❑ Drooping Eyelid ❑ Eye Infections ❑ Tearing ❑ Halos around lights ❑ Prominent Eyes ❑ Eye Injury ❑ Burning ❑ Glaucoma ❑ Double Vision ❑ Redness

Please list your height: _____ Weight: _____
Are you pregnant or nursing? Yes - No (circle)

FAMILY MEDICAL HISTORY

Please circle Yes or No and indicate Relationship to you for every option.

Please note any family history (Parents, Siblings, Living or Deceased) for the following:

DISEASE/CONDITION	Yes/No	
Blindness	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Cataract	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Glaucoma	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Lazy Eye	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Macular Degeneration	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Retinal Detachment	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Retinal Disease	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Arthritis	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Cancer	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Diabetes Type 1 / 2	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Heart Disease	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
High Blood Pressure	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Kidney Disease	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Lupus	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Thyroid Disease- Hyper - Hypo	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D
Other _____	Yes - No	Mother L / D - Father L / D - Sister L / D - Brother L/ D

SOCIAL HISTORY

(This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

____ Yes, I prefer to discuss my Social History with the doctor.

Are you a smoker: Current Everyday - Current Some Days - Former Smoker - Never Smoked (circle)?

Do you use tobacco products? Yes - No (circle If yes, type/amount/how long: _____

Do you use illegal drugs? Yes - No (circle) If yes, type/amount/how long:_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas: (circle yes or no for all options)

Constitutional		Sties or Chalazia	Yes - No	Emphysema	Yes - No
Fever	Yes - No	Flashes/Floater	Yes - No	Vascular/Cardiovascular	
Weight loss	Yes - No	Tired Eyes	Yes - No	Diabetes Type1 / 2	Yes - No
Gain	Yes - No	Itching	Yes - No	Heart Pain	Yes - No
Integumentary (Skin)	Yes - No	Excess Tearing/Watering	Yes - No	High Blood Pressure	Yes - No
Neurological	Yes - No	Psychiatric		High Cholesterol	Yes - No
Headaches	Yes - No	Anxiety	Yes - No	Vascular Disease	Yes - No
Migraines	Yes - No	ADD	Yes - No	Gastrointestinal	
Seizures	Yes - No	ADHD	Yes - No	Diarrhea	Yes - No
Eyes		Allergic/Immunologic	Yes - No	Constipation	Yes - No
Loss of Vision	Yes - No	Ear, Nose, Mouth, Throat		Genitourinary	Yes - No
Blurred Vision	Yes - No	Allergies/Hay fever	Yes - No	Bones/Joints/Muscles	
Distorted Vision/Halos	Yes - No	Sinus Congestion	Yes - No	Arthritis	Yes - No
Loss of Side Vision	Yes - No	Runny Nose	Yes - No	Muscle Pain	Yes - No
Dryness	Yes - No	Post-Nasal Drip	Yes - No	Joint Pain	Yes - No
Mucous Discharge	Yes - No	Chronic Cough	Yes - No	Lymphatic/Hematologic	
Sandy or Gritty Feeling	Yes - No	Dry Throat/Mouth	Yes - No	Anemia	Yes - No
Foreign Body Sens.	Yes - No	Respiratory		Endocrine	
Light Sensitivity	Yes - No	Asthma	Yes - No	Thyroid/Other Glands	Yes - No
Chronic Eye/Lid Infection	Yes - No	Chronic Bronchitis	Yes - No		

If you answered Yes to any of the above or have a condition not listed, please explain: _____
_____
_____

If you answered question (?) to any of the above, please explain: _____
_____

I, the patient/guardian/responsible party, have accurately and truthfully completed the information listed on this form. I agree that all fees incurred are my responsibility regardless of insurance coverage. I acknowledge that I have received a “Notice of Privacy Practices” regarding the use and disclosure of my health information. (Form is available at front desk.)

_____ _____

Patient/Guardian Signature Date

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

- ❑ I was given and have read Corridor Family Eyecare Notice of Privacy Practice and agree to continue my care with Corridor Family Eyecare under said terms.
- ❑ I was given Corridor Family Eyecare Notice of Privacy Practices and declined to read it but wish to continue my care with Corridor Family Eyecare under the terms of Corridor Family Eyecare privacy policies.
- ❑ I have read Corridor Family Eyecare Notice of Privacy Practice and do not wish to continue my care with Corridor Family Eyecare under said terms.
- ❑ The Notice of Privacy Practice could not be read due to the emergency nature of the care, other reason described as

  _____

  _____

(Please select one option from above)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____

Representative Relationship to Patient

I give permission to Corridor Family Eyecare to discuss my health care needs with _____ if I am unable to speak with them personally. (We recommend putting a name of a spouse/parent or power of attorney.)