sacopeevalley
EYE CARE

WELCOME TO OUR OFFICE!

DATE _____

NAME_____ **DATE OF BIRTH**_____ **AGE**_____ **M□ F□**

ADDRESS/PHONE/E-MAIL

STREET_____ HOME PHONE_____
PO BOX_____ CELL PHONE_____
TOWN_____ WORK PHONE_____
STATE_____ ZIP_____ E-mail:_____
May we contact you by e-mail (for reminders/recalls)? YES□ NO□

STATUS: SINGLE□ MARRIED□ DIVORCED□ WIDOWED□

EMPLOYER (SCHOOL) _____ **OCCUPATION (GRADE)** _____
SPOUSE OR PARENT NAME_____ **EMPLOYER**_____

METHOD OF PAYMENT: CASH□ CHECK□ CREDIT/DEBIT CARD□ CARE CREDIT□
DO YOU PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT? NO□ YES□
INSURANCE COMPANY (please present card) _____
SOCIAL SECURITY NUMBER _____-_____-_____ (Patient□ or Parent□)

DATE OF LAST EYE EXAM_____ **WHERE?** _____
WHAT PROBLEMS ARE YOU HAVING WITH YOUR EYES OR VISION? _____
_____

HAVE YOU HAD ANY OF THE FOLLOWING?:
Cataracts□ Double Vision□ Drooping Eyelid□ Dry Eyes□ Eye Infections□ Eye Injury□ Eye Turn□
Excessive Tearing□ Flashes of Light□ Glaucoma□ Itchy Eyes□ Lazy Eye□ Prominent Eyes□ Retinal Disease□

DOYOU WEAR GLASSES?: NO□ YES□ **HOW OLD ARE THEY?**_____
DO YOU WEAR CONTACT LENSES? NO□ YES□
TYPE: SOFT□ CONTINUOUS WEAR□ GAS PERMEABLE□ OTHER_____
How old are your present contact lenses? _____
Are they comfortable? YES□ NO□
ARE YOU INTERESTED IN WEARING CONTACT LENSES? YES□ NO□
HAVE YOU HAD ANY SERIOUS EYE PROBLEMS OR EYE SURGERY? NO□
YES□ Explain _____
NAME OF FAMILY PHYSICIAN _____**PHONE**_____
ADDRESS _____

****CONTINUED ON NEXT PAGE****

REVIEW OF SYSTEMS

PLEASE MARK ONLY THOSE THAT APPLY TO **YOU**:

[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Bronchitis
[ ] Cancer: Type_____
[ ] Chest Pain (angina)
[ ] Co1itis/Diverticulitis
[ ] Congestive Heart Failure
[ ] Depression
[ ] Diabetes
[ ] Eczema
[ ] Elevated Cholesterol
[ ] Emphysema
[ ] Enlarged Prostate
[ ] Frequent Cough
[ ] Frequent Heartburn
[ ] Hard of hearing
[ ] Hay Fever
[ ] Heart Attack
[ ] Heart Disease
[ ] Hepatitis
[ ] High Blood Pressure
[ ] HIV/AIDS
[ ] Irregular Heartbeat
[ ] Kidney Disease (dialysis?)
[ ] Migraine (or other severe headache)
[ ] Multiple Sclerosis
[ ] Muscular Dystrophy
[ ] Nose or Throat Problems
[ ] Parkinson's Disease
[ ] Psychiatric Illness
[ ] Shortness of breath
[ ] Sinusitis
[ ] Skin Disorders
[ ] Stroke
[ ] Thyroid Disease
[ ] Tuberculosis
[ ] Ulcer
[ ] Unexplained Fever
[ ] Weakness of an extremity
[ ] Weight gain or loss

Any other medical problems not listed above? Exp1ain_____

WOMEN: ARE YOU PREGNANT OR NURSING? NO□ YES□

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:_____

_____

ALLERGIC TO ANY MEDICATIONS? NO□ YES□ Explain_____

_____

IS THERE A FAMILY HISTORY OF?

[ ] Diabetes [ ] Heart Disease [ ] High Blood Pressure [ ] Cancer [ ] Arthritis [ ] Thyroid
[ ] Cataracts [ ] Glaucoma [ ] Macular Degeneration [ ] Retinal Detachment

SOCIAL HISTORY

DO YOU SMOKE? NO□ YES□ HOW MUCH ?(packs/day) _____
DO YOU DRINK ALCOHOL? NO□ YES□ (rarely□ occasionally□ frequently□)
DO YOU USE ANY RECREATIONAL DRUGS? NO□ YES□ Type _____
HOBBIES/SPORTS/SPECIAL INTERESTS _____

HOW DID YOU HEAR ABOUT US?

Newspaper□ Insurance□ Website□ Saw Sign□ Family Member/Friend□
Name of family member or friend (so that we may thank them) _____

The mission of Sacopee Valley Eye Care is to improve the quality of life of our patients by providing efficient and personal service, education about their eye health, and products of the highest quality in a friendly and comfortable environment.

Visit our website at www.sveyecare.com