OFFICE USE ONLY:
Date _____
[ ] Iwellness
Account # ____

sacopeevalley
EYE CARE

WELCOME TO OUR OFFICE!

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

ADDRESS/PHONE/E-MAIL
MAILING ADDRESS_____
TOWN_____
STATE_____ ZIP_____
E-mail: _____

(Please CIRCLE your preferred phone number)
HOME PHONE_____
CELL PHONE_____
WORK PHONE_____

May we contact you by e-mail (for reminders/newsletters) YES□ NO□
MARITAL STATUS: SINGLE□ DIVORCED□ WIDOWED□ MARRIED□ **SPOUSE NAME** _____
SOCIAL SECURITY NUMBER _____-_____-_____
PARENT/GUARDIAN NAME _____**Parent Date of Birth**___/___/____(FOR CHILDREN)

EMERGENCY CONTACT
NAME_____ PHONE_____ RELATIONSHIP_____
FAMILY PHYSICIAN
NAME OF DOCTOR OR OFFICE_____PHONE_____
ADDRESS _____

METHOD OF PAYMENT: CASH□ CHECK□ CREDIT/DEBIT CARD□ CARE CREDIT□
INSURANCE COMPANY (please present card) _____
EMPLOYER (Or School**)** _____ **OCCUPATION (**Or Grade**)** _____

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□
HAVE YOU HAD ANY SERIOUS EYE PROBLEMS OR EYE SURGERY? NO□ YES□ Explain_____
_____

DOYOU WEAR GLASSES? NO□ YES□ **HOW OLD ARE THEY?**_____
DO YOU WEAR CONTACT LENSES? NO□ YES□
IF YES, WHAT TYPE: SOFT□ CONTINUOUS WEAR□ GAS PERMEABLE□ OTHER_____
How old are your present contact lenses? _____ Brand of current lenses? _____
Are they comfortable? YES□ NO□
IF NO, ARE YOU INTERESTED IN WEARING CONTACT LENSES? YES□ NO□

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

REVIEW OF SYSTEMS

PLEASE MARK ONLY THOSE THAT APPLY TO **YOU**: Check here if None apply [ ]

[ ] 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: Check here for NONE [ ]

_____

_____

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 _____
ON AVERAGE, HOW MANY HOURS PER DAY DO YOU SPEND ON COMPUTERS, TABLETS, AND OR CELLPHONES? ___ HRS

HOW DID YOU HEAR ABOUT US?

Shopper's Guide□ Bridgton News□ Insurance□ Google□ Facebook□ Twitter□ Saw Sign□
Please tell us who referred you: _____

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 eye health, and products of the highest quality in a friendly and comfortable environment

Visit our website at www.sveyecare.com