Welcome to **St. Anthony** Eye Clinic

Last Name:________________________ First Name:___________________________ Middle Initial: _____ Date of Birth: _____________

Sex: M / F   Optional SSN: X X X/ X X/________ Spouse:____________________________________ Date of Birth: _________

Address:____ City:___________________________________

State:___________ Zip:_____________ E-mail Address:____

Home Ph: ( )__________________ Work Ph: ( )__________________ Cell Ph: ( )___________________

Preferred method of communication ☐ Email ☐ Text ☐ Postcard

Employer or School : ______________________________ Occupation or School Grade : _________________________________

Insurance Member Name: _________________________ Relationship: ______________ Date of Birth: ________________

How did you find out about our office? ____

Please check the correct response:

Preferred Language: ___*English* ___*Spanish* ___*Other*

Ethnicity: ___*Hispanic/Latino* ___*Other*

Race: ___ *Asian* ___*Black/African American* ___*Hispanic*
___*Native American* ___*Pacific Islander* ___*White* ___*Other*

CASE HISTORY:

Date of Latest Eye Exam: ___________ Clinic/Eye Doctor's Name: ____________________________________

Date of Latest Medical Exam: ____________ Primary Physician/Clinic: _________________________________

Women: Are you currently pregnant or nursing? No / Yes

Do you wear Glasses? No / Yes: Full time / Part time / Work only / Driving only / Reading only

Do you wear Sunglasses? No / Yes: Prescription / Non-Prescription

Do you wear Contacts? No / Yes: Soft / Disposable / Gas Permeable (RGP). Brand: _______________
If No, are you interested in trying contacts? Yes / No

Are you bothered by halos and glare while driving at night? Yes / No

Have you ever had an Eye Injury? No / Yes: Which Eye? R / L Type of injury: ________________

Have you ever had Eye Surgery? No / Yes: Why? _______________________________________

Do you currently use Eye Drops? No / Yes: Why? _______________________________________

Are you taking Vitamins or Supplements for your eyes? No / Yes: Brand: ____________________________

Have you ever been diagnosed with…

Cataracts? No / Yes: When?_______________________ Macular Degeneration? No / Yes: When?________________________

Glaucoma? No / Yes: When?_______________________ Detached Retina? No / Yes: When?________________________

Please list any medications, drugs, vitamins, herbals that you are currently taking:

1 ____________________________ for____________________ 4 ____________________________ for____________________

2 ____________________________ for____________________ 5 ____________________________ for____________________

3 ____________________________ for____________________ 6 ____________________________ for____________________

Please CIRCLE any CURRENT SYMPTOMS:

Blurred Distance Vision	Blurred Near Vision	Double Vision	Eye Strain	Tired Eyes
Burning Eyes	Itchy Eyes	Dry Eyes	Red Eyes	Watery Eyes
Floaters or Spots	See Flashes	Loss of Vision	Mucus Discharge	Sandy/Gritty Feeling
Headaches	Eye Pain/Soreness	Droopy Eyelid	Light Sensitive	

MEDICAL HISTORY: CHECK ANY THAT APPLY. If none – CHECK 'None'

Cardiovascular: ___ Heart Disease ___ Stroke ___ High Blood Pressure ___ High Cholesterol ___ Other: ___**None**	**Neurological:** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other: ___**None**	**Endocrine:** ___ Diabetes - Non-Insulin Dependent ___ Diabetes - Insulin Dependent ___ Thyroid Condition ___ Hormonal Dysfunction ___ Other: ___**None**	**Respiratory:** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other: ___**None**
Psychiatric: ___ ADHD ___ Depression ___ Schizophrenia ___ Other ___**None**	**Ear/Nose/Throat:** ___ Hearing Loss ___ Chronic Sinus Infections ___ Other: ___**None**	**Constitutional:** ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other: ___**None**	**Gastrointestinal:** ___ Crohn's ___ Colitis ___ Other: ___**None**
Dermatologic: ___ Eczema ___ Rosacea ___ Psoriasis ___ Other: ___**None**	**Immunologic:** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other ___**None**	**Musculoskeletal:** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other: ___**None**	**Hematological:** ___ Anemia ___ Leukemia ___ Other: ___**None**
Allergies to Environmental or Seasonal Causes: Please List – with physical reactions: ___**None**	**Allergies to Medications:** Please List – with physical reactions: ___**None**	**Tobacco Use:** **No Yes** Amount: ___**None**	**Alcohol Use:** **No Yes** Amount: ___**None**

FAMILY HISTORY: Has anyone in your family been diagnosed with these DISEASES or CONDITIONS?
Who? G = Grandparents, P = Parents, S = Siblings.

High Blood Pressure:	No / Yes ___________	Blindness:	No / Yes ___________
Diabetes:	No / Yes ______________	Cataracts:	No / Yes ___________
Cancer:	No / Yes ______________	Glaucoma:	No / Yes ___________
Heart Disease:	No / Yes ___________	Macular Degeneration:	No / Yes ___________
Thyroid Disease:	No / Yes ___________	Retinal Detachment:	No / Yes ___________
Lupus:	No / Yes ______________		

Note: Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies!!! Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. ______*initial*

HIPAA Privacy Practices: I acknowledge that I have the option of receiving the St Anthony Eye Clinic Notice of Privacy Practices.

Signature: ____ Date: _______________________

If you are under 18, parental signature is required.