St Anthony Eye Clinic New Patient Information

First Name:__________________ Last Name:________________________ Middle Initial: ____ Date of Birth:_____________ Sex: M / F

Social Security #: _____-____-_____ Spouse First Name: ________________Spouse Last Name: __________________

Preferred method for reminders and notifications: ☐ Email ☐ Cell phone

Address:____ City:____________________________________

State:___________ Zip:_____________ Email Address:____

Home Ph: ( )_________________ Work Ph: ( )_________________ Cell Ph: ( )_________________

Spouse/Emergency Contact Name: ___________________________________ Phone: _____________________________

Employer or school: __________________________________Occupation: ______________________________________

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*

Race: ___ *Asian* ___*Black/African American* ___*Native American*

___*Pacific Islander* ___*White* ___*Other*

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

CASE HISTORY:

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

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

Do you wear glasses? No / Yes: Full time / Reading only / Distance only / Computer only

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

Do you wear contact lenses? No / Yes: Soft / Gas Permeable (RGP).

Brand: _______________ Solution Brand: ________________________

If No, are you interested in trying contacts? Yes / No

Have you ever been diagnosed with:

Cataracts?	No / Yes: When?________________________
Age-related Macular Degeneration?	No / Yes: When?________________________
Glaucoma?	No / Yes: When?________________________
Diabetes?	No / Yes: When?________________________
Diabetic Retinopathy?	No / Yes: When?________________________
Dry Eye?	No / Yes: When?________________________
Eye infection, inflammation or allergy?	No / Yes: When?________________________
Floaters and/or flashes of light?	No / Yes: When?________________________
Iritis or Uveitis?	No / Yes: When?________________________
Retina defects or degenerations?	No / Yes: When?________________________
Other?	No / Yes: When?________________________

Have you ever had any previous eye surgeries? No / Yes: When?_________________________

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

1 _____________________________ for____________________ 4 _____________________________ for____________________

2 _____________________________ for____________________ 5 _____________________________ for____________________

3 _____________________________ for____________________ 6 _____________________________ for____________________

Please CIRCLE if you are CURRENTLY having any of the following eye concerns:

Redness	Burning	Itching	Tearing	Discharge
Blurred vision	Eyestrain	Eye pain	Severe sensitivity to lights	Headache
Poor night vision	Bothersome night glare	Double vision	Total loss of vision	

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

Constitutional: ___ None ___ Developmental Disability ___ Cancer ___ Fatigue Syndrome ___ Other:	**Cardiovascular:** ___ None ___ Hypertension ___ Stroke/CVA ___ Heart Disease ___ Vascular Disease ___ Congestive Heart Failure ___ Other:	**Genitourinary:** ___ None ___ Kidney Disease ___ Prostate disease/cancer ___ Benign Prostate Hypertrophy ___ Pregnancy (currently) ___ Nursing (currently) ___ Chlamydia ___ Herpes ___ Other:	**Endocrine:** ___ None ___ Type 2 Diabetes - Mellitus ___ Type 1 Diabetes - Mellitus ___ Thyroid Dysfunction ___ Hormonal Dysfunction ___ Other:
Ear/Nose/Throat: ___ None ___ Hearing Loss ___ Sinusitis ___ Dry Mouth ___ Laryngitis ___ Other:	**Respiratory:** ___ None ___ Smoker ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Sleep Apnea ___ Other:	**Musculoskeletal:** ___ None ___ Arthritis ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Osteoporosis ___ Gout ___ Other:	**Hematological:** ___ None ___ Anemia ___ Large-volume blood loss ___ Ulcer ___ Hypercholesterolemia ___ Other:
Neurological: ___ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Stroke/CVA ___ Migraine ___ Autism Spectrum Disorder ___ Other:	**Gastrointestinal:** ___ None ___ Crohn's ___ Colitis ___ Ulcer ___ Acid Reflux ___ Celiac Disease ___ Other:	**Dermatologic:** ___ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Herpes Simplex/Cold Sores ___ Herpes Zoster/Shingles ___ Other:	**Immunologic:** ___ None ___ Drug Allergies ___ Environmental Allergies ___ Rheumatoid Arthritis ___ Lupus ___ Sjogren's Syndrome ___ Other:
Psychiatric: ___ None ___ Depression ___ Attention Deficit ___ Anxiety Disorder ___ Bipolar Disorder ___ Other:	**Allergies to Environment or seasonal causes:** ___ None Please list with physical reactions:	**Allergies to Medications:** ___ None Please list with physical reactions:	**Tobacco Use** Yes / No Amount: **Alcohol Use:** Yes / No Amount:

FAMILY HISTORY: **Has anyone in your family been diagnosed with these DISEASES or CONDITIONS?**
Who? Father, Mother, Brother, Sister, Son, Daughter

Cancer:	No / Yes / Unknown___________	Hypothyroidism:	No / Yes / Unknown___________
Diabetes Mellitus Type1	No / Yes / Unknown___________	Cataracts:	No / Yes / Unknown___________
Diabetes Mellitus Type 2:	No / Yes / Unknown___________	Glaucoma	No / Yes / Unknown___________
Hypertension:	No / Yes / Unknown ___________	Macular Degeneration:	No / Yes / Unknown___________
Hyperthyroidism:	No / Yes / Unknown ___________		