Stewart Family Eye Care

**CONFIDENTIAL**

# PATIENT INFORMATION

*Thank you for choosing Stewart Family Eye Care for your vision and eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*
*(Please Print)*

Name _____ Date _____ Patient No._____
First Middle Last

Address_____ City_____State_____ Zip _____

Birth date _____ Home phone #_____ Work phone #_____

Do you prefer calls at: Home Work Either

Are you: Minor Married Divorced Single Widowed

You or your parent's employer_____ Occupation _____

Business Address_____ City_____ State _____ Zip _____

Spouse or parent's name_____ Workplace _____ Work phone # _____

If you are a student, name of school/college_____ State _____ Zip _____

Whom may we thank for referring you to us?_____

Person to contact in case of emergency_____ Phone # _____

# INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security #_____ Date employed_____

Name of employer _____ Work phone # _____

Address_____ City_____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer _____

Insurance Co. Address _____ City_____ State _____ Zip _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE BELOW:

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security #_____ Date employed_____

Name of employer _____ Work phone # _____

Address_____ City_____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer _____

Insurance Co. Address _____ City_____ State _____ Zip _____

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# HEALTH HISTORY

Name _____ Age _____ Reason for today's exam _____

Date of last exam _____ Name of eye doctor_____

Please list all prescription medications that you are currently taking, including eye drops and aspirin.

_____

## YOUR PAST/PRESENT EYE HISTORY

Please indicate whether or not you currently have (or have had) any of the following:

| Yes | No | |
|---|---|---|
| _____ | _____ | Diabetic Eye Disease |
| _____ | _____ | Glaucoma |
| _____ | _____ | Macular Degeneration |
| _____ | _____ | Eye Surgery |
| _____ | _____ | Crossed Eye or Lazy Eye |
| _____ | _____ | Laser Surgery |
| _____ | _____ | Cataracts |
| _____ | _____ | Cataract Surgery |
| _____ | _____ | Ocular Trauma |
| _____ | _____ | Retinal Tear or Detachment |
| _____ | _____ | Itching, Burning, Stinging, or Dryness |
| _____ | _____ | Herpes around the Eye |
| _____ | _____ | Other_____ |

## YOUR FAMILY MEDICAL HISTORY

Please indicate whether or not anyone in your family currently have (or have had) any of the following:

| Yes | No | |
|---|---|---|
| _____ | _____ | Macular Degeneration |
| _____ | _____ | Glaucoma |
| _____ | _____ | History of Crossed or Lazy Eye |
| _____ | _____ | Retinal Detachment |
| _____ | _____ | Blindness |
| _____ | _____ | Diabetes |
| _____ | _____ | High Blood Pressure or Stroke |
| _____ | _____ | Vessel/Heart Disease |
| _____ | _____ | Kidney Disease |
| _____ | _____ | Bleeding or Blood Clotting Disorder |
| _____ | _____ | Cancer |
| _____ | _____ | Other_____ |

## SOCIAL HISTORY

Alcohol use: frequency _____ amount_____
Tobacco use: amount per day _____
Caffeine use: amount per day _____

## ALLERGIC/IMMUNOLOGIC HISTORY

| Yes | No | |
|---|---|---|
| _____ | _____ | Medication Allergies_____ |
| _____ | _____ | HIV/AIDS |
| _____ | _____ | Lupus/Sjogrens |
| _____ | _____ | Allergies/Hay Fever |
| _____ | _____ | Latex Allergy |

## REVIEW OF SYSTEMS

Please indicate whether or not you currently have (or have had) any of the following:

| Yes | No | |
|---|---|---|
| | | **General Constitutional** |
| _____ | _____ | Recent, unexplained, weight gain |
| _____ | _____ | Surgeries_____ |
| _____ | _____ | Tumor or Cancer_____ |
| _____ | _____ | Do you have a pacemaker? |
| _____ | _____ | Are you nursing or pregnant? |
| | | **Ears, Nose, Mouth, Throat** |
| _____ | _____ | Ear, Nose, Mouth or Throat problems (please circle) |
| | | **Heart/Vessels-Cardiovascular** |
| _____ | _____ | High blood pressure |
| _____ | _____ | Stroke |
| _____ | _____ | Heart Problems_____ |
| | | **Breathing-Respiratory** |
| _____ | _____ | Breathing problems |
| _____ | _____ | Asthma |
| _____ | _____ | TB (Tuberculosis) |
| | | **Stomach/Bowel-Gastrointestinal** |
| _____ | _____ | Stomach or Intestinal Problems |
| _____ | _____ | Hepatitis, Jaundice or Liver Disease |
| | | **Genital/Urinary-Genitourinary** |
| _____ | _____ | Genital/Urinary Problems |
| | | **Bone/Muscle-Musculoskeletal** |
| _____ | _____ | Arthritis/Bone or Joint Problems |
| _____ | _____ | Back Pain |
| _____ | _____ | Rheumatoid Arthritis |
| | | **Skin/Tissue-Integumentary** |
| _____ | _____ | Dermatological Problems |
| _____ | _____ | Skin Cancer |
| | | **Nerve-Neurological** |
| _____ | _____ | Seizers/Nervous Systems Disorders |
| _____ | _____ | Head Injury |
| _____ | _____ | Multiple Sclerosis |
| _____ | _____ | Recurring Headaches |
| | | **Pyschiatric** |
| _____ | _____ | Depression/Anxiety/Insomnia/Mental Illness (please circle) |
| | | **Endocrine** |
| _____ | _____ | Thyroid Disease |
| _____ | _____ | Sugar Diabetes |
| | | **Hematologic/Lymphatic** |
| _____ | _____ | Bleeding or Blood Clotting Disorders |
| _____ | _____ | Cholesterol Problems |