KINNELON EYECARE
Excellence In Vision

# Existing Patient Info

*Starred fields required

*First Name: ________________________________________

*Last Name: ________________________________________

*Date of Birth: ___/___/_________

Address (If update required): ________________________________________________

City: _______________________ State: _________________ Zip:__________________

*Mobile Phone #: (_____) -_______-________

*Email Address: _________________________

*Name of Vision Insurance:

☐ EyeMed ☐ VSP

Medical Insurance

*Insurance Name: _______________________ *Member ID #: _________________________

Guarantor Name: _______________________ Guarantor Date of Birth: ___/___/__________

Guarantor Last 4 Digits of SSN#: ___________

**PHARMACY INFO**

NAME: ______________________ ZIPCODE: ______________________

ADDRESS: ______________________ PHONE: ______________________

**MEDICAL HISTORY**
Do you have or have you had

○ NONE ○ Arthritis ○ Hypertension (High Blood Pressure) ○ Hyperthyroidism

○ Asthma ○ Hypercholesterolemia (Cholesterol) ○ Hypothyroidism

○ Diabetes Type 1 or 2 ○ Stroke ○ Other______________

○ CANCER TYPE: ______________________

PAST SURGERY: ______________________ DATE: ______________

**OCULAR HISTORY**
Do you have or have you had

○ NONE ○ Cataract R / L ○ Glaucoma R / L ○ Strabismus (Eye Turn) R / L

○ Contacts R / L ○ Macular Degeneration R / L ○ Other Eye Condition:______________

○ Glasses R / L ○ Retinal Tear R / L ○ Other Eye Condition:______________

PAST EYE SURGERY: ______________________ DATE: ______________

**CURRENT MEDICATIONS**

○ NONE

○ SEE ATTACHED LIST

NAMES & DOSAGES OF MEDICATIONS

______________ ______________

______________ ______________

______________ ______________

**ALLERGIES**

TO MEDICATIONS: ○ NONE

NAME OF MEDICATIONS: REACTION:

______________ ______________

______________ ______________

OTHER ALLERGIES: ○ NONE

______________ ______________

______________ ______________

**SOCIAL HISTORY**

SMOKING ○ NEVER ○ FORMER SMOKER ○ CURRENT, EVERY DAY ○ CURRENT SOME DAYS

ALCOHOL ○ NEVER ○ LESS THAN 1 DRINK / DAY ○ 1-2 DRINKS / DAY ○ 3 OR MORE DRINKS/DAY

**FAMILY HISTORY**

○ Macular Degeneration / Relation: ________ ○ Coronary Artery Disease / Relation: ______ ○ Other:____________ / Relation: ______

○ Glaucoma / Relation: ________ ○ Stroke / Relation: ______ ○ Other:____________ / Relation: ______

○ Retinal Detachment / Relation: ________ ○ Diabetes Type 1 or 2 / Relation: ______ ○ None

○ Atrial Fibrillation or Irregular Heartbeat Relation:________

○ CANCER: Type: ______________ Relation: ________ Type: ______________ Relation: ______________

**REVIEW OF SYSTEMS**
Are you experiencing

○ Poor Vision ○ Tearing ○ Seeing Floaters ○ Congestion ○ Headaches

○ Double Vision ○ Eye Redness ○ Weight Loss ○ Shortness ofBreath ○ Other: ______________

○ Eye Pain ○ See Flashing Lights ○ Rapid Heartbeat ○ Dry Mouth ○ Other: ______________