KINNELON EYECARE

PLEASE PRINT CLEARLY

NAME:_____ ***DOB:*** _____ ***__MALE __FEMALE***

PREFERRED LANGUAGE: ***__English __Spanish __Other:*** _____ ***__Declined to Specify***

RACE: ***__African American __Asian __Hispanic __White __Other*** _____ ***__Declined to Specify***

PREFERRED COMMUNICATION: ***__ PHONE __TEXT __ POSTAL: __ Address Confirmed***
__ EMAIL: _____

ETHNICITY: ***__Hispanic/Latino __Not Hispanic/Latino __Native Hawaiian / Other Pacific Island __Decline to Specify***

REFERRED BY: ***__Another Patient __Professional – Name:*** _____ ***__ None***

PHARMACY INFO Name: _____ Phone #: _____
Address: _____ Fax #: _____

MEDICAL HISTORY

Do you have or have you had :

__ Arthritis __ Hypertension (High Blood Pressure) __Hyperthyroidism
__ Asthma __ Hypercholesterolemia (Cholesterol) __Hypothyroidism
__ Diabetes: Type 1 or 2 __ Stroke
__ Other: _____ __Cancer - Type:_____

PAST SURGERY: _____ Date: _____
_____ Date: _____

OCULAR HISTORY

Do you have or have you had:

__ Cataract R / L __ Glasses __ Macular Degeneration R / L
__ Contacts __ Glaucoma R / L __ Retinal Tear R / L
__ Other Eye Condition: _____ __ Strabismus (Eye Turn)

PAST EYE SURGERY: _____ Date: _____
_____ Date: _____

CURRENT MEDICATIONS

_____ _____ _____
_____ _____ _____

ALLERGIES

TO MEDICATIONS _____ Reaction: _____
_____ Reaction: _____
OTHER ALLERGIES: _____ Reaction: _____

SOCIAL HISTORY

SMOKING __ Never __ Former Smoker __ Current Every Day __Current Some Days __Cigar
ALCOHOL __Never __Less than 1 drink per day __1-2 drinks per day __ 3 or more drinks per day

FAMILY HISTORY

__ Macular Degeneration: Relation: _____ __ Diabetes: Type 1 or 2 Relation: _____
__ Glaucoma: Relation: _____ __ Coronary Artery Disease: Relation: _____
__ Retinal Detachment: Relation: _____ __ Stroke: Relation: _____
__ Atrial Fibrillation (Irregular Heartbeat): Relation: _____
__ ***CANCER***: Type: _____ Relation: _____
_____ Relation: _____

REVIEW OF SYSTEMS

Are you experiencing

__ Poor Vision __ Eye Redness __ Weight Loss
__ Double Vision __ Seeing Flashing Lights __ Rapid Heart Beat
__ Eye Pain __ Seeing Floaters __ Congestion
__ Tearing __ Headaches __ Shortness of Breath
__ Other: _____ __ Dry Mouth

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PATIENT INFORMATION FORM

Excellence In Vision

DATE: _____

LAST NAME: _____ **FIRST NAME:** _____ **DOB**: _____

ADDRESS: _____ **CITY:** _____ **STATE**:_____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **DAY PHONE**: _____

SOCIAL SECURITY #: _____ **EMPLOYER NAME**: _____

PRIMARY MEDICAL INSURANCE: _____

PRIMARY INSURED NAME: _____

PRIMARY INSURED SS#: _____

PRIMARY INSURED DOB: _____

SECONDARY MEDICAL INSURANCE: _____

SECONDARY INSURED NAME: _____

SECONDARY INSURED SS#: _____

SECONDARY INSURED DOB: _____

PRIMARY INSURED VISION INSURANCE: _____

PRIMARY INSURED NAME: _____

PRIMARY INSURED SS#: _____

PRIMARY INSURED DOB: _____

SECONDARY VISION INSURANCE: _____

SECONDARY INSURED NAME: _____

SECONDARY INSURED SS#: _____

SECONDARY INSURED DOB: _____