PrivateEyes Optometry

Welcome to Private Eyes Optometry!

Thank you for choosing us for your eyecare needs. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Name (Last, First): _____ Male ☐ Female ☐

Address: _____ City/State/Zip: _____

Date of Birth: _____ Single ☐ Married ☐ Other ☐ Social Security #:_____

Best number to reach you at: _____(Home/Cell/Work) Email: _____

Do you have vision insurance? Yes ☐ No ☐ If yes, name: _____.

Person Responsible for Account: _____Do you have health insurance? Yes ☐ No ☐

If yes, name of insurance: _____. Member ID#: _____

Were you referred to our office? Yes ☐ No ☐ Whom may we thank for this referral?_____

If not referred, how did you hear about us? _____

SOCIAL HISTORY

This information is required by insurance carriers and is kept strictly confidential.

Full Time Student ☐ Part Time Student ☐ Employed ☐ Retired ☐ Other:_____

Occupation: _____ Years ____ Employer: _____

Hobbies/Interests: _____

	Yes	No	
Do you use tobacco?	☐	☐	If yes, type/amount/how often: _____
Do you drink alcohol?	☐	☐	If yes, type/amount/how often: _____
Do you use illegal drugs?	☐	☐	If yes, type/amount/how often: _____
Do you use a computer?	☐	☐	If yes, how many hours a day? _____

Any visual symptoms after using the computer? Yes ☐ No ☐

If yes, please describe those symptoms: _____

VISUAL HISTORY

Main reason for having an examination today: _____

Date of last evaluation: _____ Doctor's Name: _____

Please check all that apply:

I currently wear: Glasses ☐ Contacts ☐ If Contact Lenses: Soft ☐ RGP ☐ Duette Lenses ☐

What solution do you use?_____ Are you happy with your contact lenses?_____

Do you use any eyedrops (Rx or OTC)? Yes ☐ No ☐

If yes, please list name/how often used: _____

Do you have a history of any of the following?

	Yes	No
Blindness	☐	☐
Eye turn (Strabismus)	☐	☐
Lazy Eye (Amblyopia)	☐	☐
Vision Therapy	☐	☐
Eye Infection	☐	☐
Keratoconus	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Retinal Detachment	☐	☐
Other Eye Disease	☐	☐

Do you currently experience any of the following?

	Yes	No
Headaches	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Eye Pain	☐	☐
Glare/Light sensitivity	☐	☐
Frequent styes	☐	☐
Redness	☐	☐
Itchiness	☐	☐
Burning	☐	☐
Excess tearing	☐	☐
Dryness	☐	☐

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	Yes	No
Nausea when doing visual tasks	☐	☐
Motion sickness/Car sickness	☐	☐
Halos around lights	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Sandy/Gritty feeling	☐	☐

When reading, do you:

	Yes	No
Close or cover one eye	☐	☐
Lose your place	☐	☐
Have poor reading comprehension	☐	☐
See words moving or floating	☐	☐
Lose your attention easily	☐	☐

List any eye surgeries, injuries or other diseases:

_____

PERSONAL MEDICAL HISTORY/ REVIEW OF SYSTEMS

When was your last health exam?_____ Have you taken the flu shot this year? Yes ☐ No ☐

Past significant illnesses or injuries: _____

Past surgeries: _____

List all current medications you are currently taking (including OTC/vitamins):

_____

Medicines that cause reactions or sensitivities: _____

Specific allergies: _____. Ladies, are you pregnant? Yes ☐ No ☐

Do you have, or ever had, any CHRONIC problems in the following areas?

	Yes	No		Yes	No
Neurological	☐	☐	Cardiovascular	☐	☐
Migranes	☐	☐	High Blood Pressure	☐	☐
Seizures	☐	☐	Stroke	☐	☐
Multiple Sclerosis	☐	☐	Gastrointestinal	☐	☐
Endocrine	☐	☐	Genitourinary	☐	☐
Diabetes	☐	☐	Musculoskeletal	☐	☐
Thyroid problems	☐	☐	Arthritis	☐	☐
Ear/Nose/Throat	☐	☐	Skin problems	☐	☐
Allergies/Hay Fever	☐	☐	Lymphatic/Hematological	☐	☐
Ear Infections	☐	☐	Anemia	☐	☐
Dry throat/mouth	☐	☐	Cancer	☐	☐
Breathing Problems	☐	☐	Psychiatric Disorder	☐	☐
Asthma	☐	☐	Developmental Delay	☐	☐
Emphysema	☐	☐	ADD/ADHD	☐	☐

Other_____

If Yes to any of the above, please explain: _____.

FAMILY HISTORY

☐ Family history is unknown/ adopted What is your preferred language?_____

Race/Ethnicity:_____ ☐ Decline to state

Any history of the following in any family members (parents, grandparents, siblings, children)?

	Yes	No	Relationship		Yes	No	Relationship
Poor Vision	☐	☐	_____	Blindness	☐	☐	_____
Eye turn (Strabismus)	☐	☐	_____	Glaucoma	☐	☐	_____
Lazy eye (Amblyopia)	☐	☐	_____	Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____	Cancer	☐	☐	_____
Retinal Detachment	☐	☐	_____	Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____	Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____	Other Inherited Disease:			_____

Patient/Guardian Signature:_____ Date:_____

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