Welcome to Crystal Eyecare

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name ______________________ Nickname ______________ Date________________

Street ______________________ City ______________________ State________ Zip________________

Date of Birth____/____/______ Age _____ Sex M F Social Security ______-______-________ Email ______________________

Home Phone ______________________ Work Phone ______________________ Cell Phone ______________________

Preferred method of communication ☐ Home ☐ Work or ☐ Cell

Reason for today's visit? ☐ Glasses ☐ Contacts ☐ Medical

Who May We Thank for Referring You? ______________________ If medical, specify: ______________________

For public health purposes: The government is requesting that health care providers collect the following information from patients:

1. **Blood Pressure**: ________________ 2. **Primary Language**: ______________________
3. **Race**: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other
4. **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Health History

Family Dr. ______________ Family Dr. Phone # ______________ Last Physical Exam ______________ Date of Last Eye Exam ______________

Do you use tobacco products? Y/N Do you drink alcohol? Y/N For Women: Pregnant/Nursing? Y/N Last Eye Dr. ______________________

Do you have any of the following conditions? Please indicate YES or NO

Eyes		**Psychiatric**		**Musculoskeletal**	
Glaucoma	☐Y ☐N	Depression	☐Y ☐N	Arthritis	☐Y ☐N
Cataracts	☐Y ☐N	Anxiety	☐Y ☐N	Osteoarthritis	☐Y ☐N
Macular Degeneration	☐Y ☐N	**Cardiovascular**		Gout	☐Y ☐N
Eye surgery	☐Y ☐N	Hypertension	☐Y ☐N	**Integumentary**	
Retinal Disease	☐Y ☐N	Heart Disease	☐Y ☐N	Shingles	☐Y ☐N
Blindness	☐Y ☐N	Vascular Disease	☐Y ☐N	Breast Cancer	☐Y ☐N
Strabismus/Eye Turn	☐Y ☐N	**Respiratory**		**Endocrine**	
Amblyopia/Lazy Eye	☐Y ☐N	Asthma	☐Y ☐N	Diabetes Type 2	☐Y ☐N
Retinal Disease	☐Y ☐N	Emphysema	☐Y ☐N	Diabetes Type 1	☐Y ☐N
Dry Eye	☐Y ☐N	Sleep Apnea	☐Y ☐N	Thyroid Dysfunction	☐Y ☐N
Constitutional symptoms		Lung Cancer	☐Y ☐N	**Hematologic/Lymphatic**	
Cancer	☐Y ☐N	**Gastrointestinal**		Anemia	☐Y ☐N
Fatigue	☐Y ☐N	Colitis	☐Y ☐N	High Cholesterol	☐Y ☐N
Ear, Nose, Mouth, Throat		Ulcers	☐Y ☐N	Swelling	☐Y ☐N
Hearing Loss	☐Y ☐N	Acid Reflux	☐Y ☐N	**Allergic/Immunologic**	
Sinusitis	☐Y ☐N	Genitourinary	☐Y ☐N	Drug Allergies	☐Y ☐N
Dry Mouth	☐Y ☐N	Kidney Disease	☐Y ☐N	Environmental Allergies	☐Y ☐N
Neurological				Lupus	☐Y ☐N
Multiple Sclerosis	☐Y ☐N	**If you answered YES to diabetes:**		Sjogren's Syndrome	☐Y ☐N
Epilepsy	☐Y ☐N	**Date diagnosed:**	_____/_____/__________	Rheumatoid Arthritis	☐Y ☐N
Stroke	☐Y ☐N	**Last Blood Sugar:**	________________mg/dl		
Migraines	☐Y ☐N	**Last Hemoglobin A1C:**	_________________%		

Please list ALL medications:	What medications are you allergic to:	Please list any eye surgeries:

Please indicate if any family members have or had any of the following conditions and specify relative affected (mother, father, sister, brother, son, daughter)

Glaucoma	____________	Diabetes	____________	Hyperthyroidism	____________
Cataracts	____________	Hypertension	____________	Hypothyroidism	____________
Macular Degeneration	____________	Cancer	____________	Other ____________	____________

Lifestyle Questionnaire

Please describe your occupation ____

Computer use: ☐ **Y** ☐ **N** Hobbies & Sports ____