

BEACON ADVANCED EYECARE CENTER

WELCOME BACK TO OUR OFFICE

Date _____

Last _____ First _____ MI _____

Date of Birth _____ Age _____ Sex M F

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ SS# _____

Email Address _____

Employer or School _____

Occupation / Grade _____

Spouse or Parent's Name _____

Spouse or Parent's Date of Birth _____

What is the major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

INSURANCE INFORMATION

Vision Insurance _____

Subscriber Name _____

Subscriber SS# _____ Birth Date _____

Provider Medical Insurance _____

Subscriber Name _____

Subscriber SS# _____ Birth Date _____

Spouse's Name _____

Spouse's Birth Date _____

FAMILY MEDICAL / EYE HISTORY

Is there a family medical history of any of the following?

	Relationship
<input type="checkbox"/> Blindness	_____
<input type="checkbox"/> Cataracts	_____
<input type="checkbox"/> Corneal Problems	_____
<input type="checkbox"/> Glaucoma	_____
<input type="checkbox"/> Lazy Eye	_____
<input type="checkbox"/> Macular Degeneration	_____
<input type="checkbox"/> Retinal Problems	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Heart Disease	_____

PATIENT MEDICAL HISTORY

Name of Family Physician _____

Date of Last Physical Check-up _____

CURRENT MEDICATIONS (Rx or Over the Counter)

List name of medications including eye drops, vitamins and birth control pills _____

Allergies to medications: Yes No

Have you ever been diagnosed or treated for the following?

- | | | |
|--------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nerves |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Other _____ | | |

PATIENT EYE HISTORY

Date of Last Eye Exam _____

By Whom? _____

Do you currently wear contact lenses? Yes No

What kind? _____

Solutions used _____

Would you prefer clear contact lenses, or colored contact lenses to change the color of your eyes? _____

Have you ever tried contact lenses? Yes No

Do you..... (Check box if your answer is yes)

- ..Work at a computer?
 - ..Think you might benefit from thinner, lighter lenses?
 - ..Spend time outdoors? (how much?) _____ Hrs/week
 - ..Have prescription sunglasses?
 - ..Prefer not to wear your glasses at times?
 - ..Want information on Laser Vision Correction surgery?
 - ..Have more than 1 pair of current Rx glasses?
 - ..Have children?
 - ..Have family members in need of eye care?
- If you wear bifocals, do the lines or head tilting bother you?
 Yes No
- If you wear contact lenses, are you satisfied with the vision and comfort?
 Yes No

Have you ever been diagnosed or treated for the following?

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Corneal Abrasion | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Eye injury | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other eye disorders |

Do you experience or have you ever experienced?

- | | | |
|--|---|--|
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Flash of light | <input type="checkbox"/> Sunlight sensitivity |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Floater/spots | <input type="checkbox"/> Crossed eye/eye turn |
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Grittiness | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Itchiness | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Occasional Dryness | |