Welcome to Acuity Eyecare

Name:_____ Date_____ Birthdate ____/____/_____Age:_____
Social Security No:_____ (this is sometimes needed to file your insurance)
Address:_____ City:_____ Zip:_____
Email:_____ Phone (home, cell) (_____)_____
How would you like us to contact you? □ Text □ Email □ Call □ Other: _____
Emergency Contact Name: _____ Emergency Contact Phone Number:(_____)_____
How did you hear about us? □ Google □ Website □ Other:_____

Reason for Today's Visit

Medical Conditions: *please note that the conditions listed below are considered* ***medical*** *problems and are treated using your* ***medical*** *insurance.*

□ Dry Eyes	□ Itchy Eyes	□ Eye pain/soreness	□ Red eyes	□ Burning
□ Flashes/floaters	□ Glare/Light sensitivity	□ Double Vision	□ Swollen eyelids	□ Excess Tearing
□ Infection	□ Loss of side vision	□ Gritty feeling	□ Dry Eyes	□ Diabetic Eye Exam
□ Stye(s)	□ Foreign Body Feeling	□ Dry Eyes	□ Discharge	□ Flashes/floaters

□ Eye disease monitoring/treatment: Glaucoma – Cataract - Macular Degeneration
□ Other (please describe): _____

Vision/Wellness: *routine exams of healthy eyes without problems and measurements for new glasses or contacts are billed to your* ***vision*** *plan.*

□ Blurred distance vision □ Blurred near vision □ New glasses □ New contacts

Medical History

Last Eye Exam:_____ Last Medical Exam:_____ Pregnant or Nursing? Yes No
Do you currently, or have you ever had any problems in the following areas?

Condition	Yes	Medication
Eyes		
Retinal tear/detachment	□	_____
Glaucoma	□	_____
Macular Degeneration	□	_____
Cataract	□	_____
Dry Eyes	□	_____
Eye Allergies	□	_____
Eye Surgery	□	_____
Eye Injury	□	_____
Amblyopia	□	_____
Other: _____		
_____		
Integumentary (skin)		
Eczema/Rosacea	□	_____
Acne	□	_____
Dryness	□	_____
Neurologic		
Headaches	□	_____
Migraines	□	_____
Seizures	□	_____
Endocrine (thyroid/glands)		
Hypothyroid	□	_____
Hyperthyroid	□	_____

Condition	Yes	Medication
Ear, Nose, Mouth, & Throat		
Allergies/Hayfever	□	_____
Sinus Congestion	□	_____
Runny Nose	□	_____
Chronic Cough	□	_____
Dry Throat/Mouth	□	_____
Gastrointestinal		
Diarrhea	□	_____
Constipation	□	_____
Respiratory		
Asthma	□	_____
Chronic Bronchitis	□	_____
Emphysema	□	_____
Vascular/Cardio		
Diabetes/Pre-diabetes	□	_____
High Blood Pressure	□	_____
Stroke	□	_____
Bone/Joints/Muscle		
Rheumatoid Arthritis	□	_____
Muscle/joint Pain	□	_____
Joint Pain	□	_____
Lymphatic/Hematologic		
Anemia	□	_____
Bleeding problems	□	_____

Genitourinary: *Please specify type and treatment* _____
Psychiatric: *Please specify type and treatment* _____
Cancer: *Please specify type and treatment* _____

Medications

Do you have any allergies to medications? □ Yes □ No If yes, please list: _____
List any medication taken (including hormones, oral contraceptives, and non-prescription medications):_____
_____
_____

Social History

Do you use tobacco products? □ Yes □ No
Do you drink alcohol? □ Yes □
Do you use illegal drugs? □ Yes □ No
Indicate if you have been exposed to or infected with: □ Gonorrhea □ HIV □ Hepatitis □ Syphilis □ Herpes

Contact Lens/Glasses History

How old are your current glasses? _____ Are you wanting to get new glasses? Yes No
Are you having any specific problems with your current glasses? _____
Do you wear contacts? Yes / No
What type of contacts do you wear? (circle one) Soft Soft Toric RGP
Brand of contact lens: _____
Brand of cleaning solution: _____
Contact lens prescription: Right eye_____ Left eye _____
Wearing schedule: □ Part-time □ Full time □ Overnight wear
How frequently do you replace your contacts? □ Daily □ Bi-weekly □ Monthly □ I'd rather not say…
Do you want to continue wearing your current brand or are you interested in changing? □ Stay □ Change □ Doctor's choice

Family History

Please note any family history (parents, grandparents, siblings, and/or children for the following:

Disease/Condition	**Relationship**
Cataract	_____
Glaucoma	_____
Crossed Eyes	_____
Macular Degeneration	_____
Retinal Detachment/Disease	_____
Diabetes	_____
Cancer	_____
Heart Disease	_____
Thyroid Disease	_____
Other	_____