JOHNSON EYECARE

KEEPING YOU IN SIGHT

Patient Information

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

Marital Status □ Single □ Married □ Divorced □Widow Sex □ Male □ Female

Employer or School Name _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? □ Walk-in □ On-line □ TV □ Other □Referred _____

Referring Doctor Name: _____ Phone: _____

Address: _____

Vision Insurance Information:

Name of Company: _____ Insurance ID #: _____

Policyholder Name: _____ DOB: _____

Policyholder SS# _____ Relationship:_____

Policyholder address: _____

City: _____ State: _____ Zip Code: _____

Policyholder Employer:_____

Medical Insurance Information

Name of Company: _____ Insurance ID #: _____

Policyholder Name: _____ DOB: _____

Policyholder SS# _____Relationship:_____

Policyholder address: _____

City: _____ State: _____ Zip Code: _____

Policyholder Employer: _____

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Patient Health History

Name: _____ DOB: _____

Patient Medical Information

Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the follow information so your doctor can provide you with the most thorough care and evaluation of your eye health.

Have you had any ongoing problems with any of the following systems? Please check all that apply:

□ Gastrointestinal	□ Nervous System	□ Endocrine/Glands
□ Ear/Nose/Throat	□ Urinary Tract	□ Blood/Lymph
□ Cardiovascular/Heart Disease	□ Muscles/Bones	□ Allergic/Immunologic
□ Respiratory	□ Integument/Skin	□ Headaches
□ High Blood Pressure	□ Cancer	□ Psychiatric/Psychological

□ Diabetes (Date diagnosis: _____) □ Type I □ Type II

Other health problems: _____

Are you currently taking medications? (list) _____

_____

_____

Are you allergic to medication? _____

Do you use cigarettes/tobacco? □Yes □No

Name of Primary Care Physician: _____ Date of last visit: _____

Patient Eye History

Date of last eye exam: _____ Where / Dr.: _____

Do you currently wear? □ Prescribed Glasses □OTC Readers □ Contact lenses

Today's visit is for: □ Glasses □ Contact Lenses □Both □ Other: _____

Please check any of the following conditions you have/had:

□ Glaucoma □ Retinal Detachment □ Dry Eyes □ Cataracts □ Macular Degeneration

Do you have any other conditions or problems? If so, describe _____

Have you had a serious injury or eye surgery? If yes, please describe _____

Are you using any eye drops (prescription or over-the-counter)? _____

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Patient Eye History

Name:_____ DOB: _____

Please describe any problems with your eyes for which you are seeking treatment today:

_____

Check all that apply:

□ Itchy eyes □ Stinging/Burning □ Flashes/Floater □ Eyestrain/Eye Fatigue

□ Blurry Vision □ Red Eyes Are you planning to purchase new glasses today? □ Yes □ No

Vision Needs Checklist

1. Are you generally satisfied with the eyeglasses you're now wearing: Yes _____ No _____
2. Do you experience any ***Eye Strain*** under the following conditions?

___ Artificial/Fluorescent Lighting ___ Reading ___Computer work
___ Paperwork ___ Car headlights ___ Night driving
___ Bright sunshine ___ Snow Other: _____

3. In what ***Recreational activities*** do you participate?

___ Swimming/Diving ___ Golf ___ Cycling
___ Hunting/Shooting ___ Jogging/Running ___Skiing/snowboard
___ Boating/Fishing ___ Sewing/Crafts Other: _____

4. In what ***Sports activities*** to you participate?

___ Basketball ___ Soccer ___ Lacrosse
___ Racquet Sports ___ Tennis Other: _____

5. Are you involved in an ***Occupation*** where is potential risk to eye health such as:

___ Auto Repair ___ Landscaping ___ Painting/Carpentry
___ Electrical ___ Construction Other: _____

Family Eye & Medical History

Please check any conditions that have occurred in your immediate family:

□ Glaucoma Relation: _____ □ Cataracts Relation: _____

□ Macular Degeneration Relation: _____ □ Diabetes Relation: _____

□ Retinal Detachment Relation: _____ □ High Blood Pressure Relation: _____

Other: _____

FOR DOCTORS USE: This form was reviewed by _____ Date: _____