Treatment of Eye Diseases

Batesville Eye Care Center

WELCOME TO OUR OFFICE

Full Name ______________________

Street ______________________

City ______________ **State** ____ **Zip** ________

Home Phone ______________ **Work Phone** ______________

Cell Phone______________________

Best # to reach you ______________________

Employer ______________________

Social Security # ______________________

Email address ______________________

Health Insurance ______________________

ID# ______________________

Medicare # ______________________

Medicaid # ______________________

Current medications (Rx or Over the Counter)

		Name of Medication
Antihistamines	☐ Yes ☐ No	________
Diuretics (fluid pills)	☐ Yes ☐ No	________
Blood pressure Pills	☐ Yes ☐ No	________
Oral Contraceptives	☐ Yes ☐ No	________
Sleeping Tablets	☐ Yes ☐ No	________
Diabetic medications	☐ Yes ☐ No	________
Heart medications	☐ Yes ☐ No	________
Eye Drops/OTC & Prescribed	☐ Yes ☐ No	________
Other	☐ Yes ☐ No	________

Allergies:______________________

Family Medical History

		Relationship
Blindness	☐ Yes ☐ No	________
Cataracts	☐ Yes ☐ No	________
Glaucoma	☐ Yes ☐ No	________
Diabetes	☐ Yes ☐ No	________
Heart disease	☐ Yes ☐ No	________
Macular degeneration	☐ Yes ☐ No	________
Retinal detachment disease	☐ Yes ☐ No	________
High blood pressure	☐ Yes ☐ No	________
Crossed Eyes	☐ Yes ☐ No	________
Arthritis	☐ Yes ☐ No	________
Cancer	☐ Yes ☐ No	________
Thyroid disease	☐ Yes ☐ No	________
Lupus	☐ Yes ☐ No	________
Stroke/TIA's	☐ Yes ☐ No	________

Today's Date ____________ **Date of Last Exam** ____________

Previous Eye Doctor______________________

Date of Birth__________ **Age**________ **Sex M**____ **F**____

What is the major purpose of this visit?______________________

Spouse or Parent name______________________

How Will You Be Paying Today?

☐ **Cash** ☐ **Check** ☐ **Credit Card**

Do you…

…Work at a computer for long periods	☐ Yes ☐ No
…Have more than one pair of glasses	☐ Yes ☐ No
…Want information on thinner, lighter lenses?	☐ Yes ☐ No
…Wear Bifocals?	☐ Yes ☐ No
…(If yes, are you bothered by head tilting,	☐ Yes ☐ No
restricted areas of vision correction, etc.?)	☐ Yes ☐ No
…Always like to wear your glasses?	☐ Yes ☐ No
…Spend time outdoors? (how much)	_____ hrs/week
…Have prescription sunglasses?	☐ Yes ☐ No
…Have problems with glare or reflection	☐ Yes ☐ No
particularly when driving at night?	☐ Yes ☐ No
...Have you ever worn/are currently wearing contacts?	☐ Yes ☐ No
Are you planning on getting new contacts today?	☐ Yes ☐ No
Are you planning on getting new glasses today?	☐ Yes ☐ No
Would you like information on Lasik Correction?	☐ Yes ☐ No
Are you interested in having Lasik Correction?	☐ Yes ☐ No

SOCIAL HISTORY

Do you use tobacco products?	☐ Yes ☐ No
Do you use alcohol?	☐ Yes ☐ No
Do you use illegal drugs?	☐ Yes ☐ No__________

Have you ever been exposed to or infected with:

☐ Hepatitis ☐ HIV ☐ Gonorrhea ☐ Syphilis

☐ I wish to discuss my social history with the doctor. Check Box

Life Style

Sewing	**Y**	**N**	Play Sports	**Y**	**N**
Swim	**Y**	**N**	Gardening	**Y**	**N**
Woodworking	**Y**	**N**	Read	**Y**	**N**
Dance	**Y**	**N**	Crafts/Painting	**Y**	**N**
Hunt/Fish	**Y**	**N**	Work on Computer	**Y**	**N**
Other______________			Hours per day________		

Referred E By:______________________

Please turn form over and complete side two

Review of Systems

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

SYSTEM	YES	NO	?
CONSTITUTIONAL			
Fever, Weight loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

	YES	NO	?
EARS, NOSE, MOUTH THROAT			
Allergies, Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post Nasal Drip	☐	☐	☐
Chronic cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY	☐	☐	☐
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

____

I authorize Batesville Eyecare Physicians and Staff to perform necessary test for an comprehensive eye evaluation

____

Patient Signature

____ ____________

Doctor Signature **Date**

Date	Tech Int.	Patient History Changes	Dr. Initials
______	______	________________________________	________
______	______	________________________________	________
______	______	________________________________	________
______	______	________________________________	________