WELCOME TO STEEL CITY EYE CARE!

DOB: AGE:	Full Name:	SSN:
CELL #:	Street: Zip:	Employer:
WORK #:	EMAIL:	Occupation:
Health insurance company name and contract number:	**Cardholder name on card and DOB:**	Hobbies:
VISION INSURANCE COMPANY:	**Cardholder name on card, DOB, and last 4 SSN:**	Date last eye exam: Location:
PLEASE CHECK THE FOLLOWING: ☐ **I AGREE TO THE POSTED OFFICE AND HIPPA POLICY TERMS AND CONDITIONS AND DO NOT HAVE ANY QUESTIONS.**	**Please circle any of the following to which you object:** **-File health, vision and coordination of benefits claims with insurance** **-Obtain medication history and e-Rx medicines to pharmacy** **-Provide Rx and demographic info for online contact orders and reminders** **-Communicate with your physician, insurance company and pharmacy** **-Text Email or Leave a Voicemail for you**	Date of last physical:_____ Physician:_____ Past surgeries:_____ Females: Pregnant or nursing? Yes No

Signature_____ Date_____

What problems are you having with your EYES? (please circle and check where applicable)	Yes (√)	Past eye problems:_____ _____	Yes (√)	OTHER CONCERNS:_____ _____ _____
Blurred Vison-Far, Near, Middle		Family history Blindness		
Sudden Vison Loss		Family history of Eye Disease		Contact Brand: ○ Dispose: daily/monthly ○ Do you air-dry your case daily? Y/N ○ Solution brand:_____
"Tired Eyes"/Eye Strain		Glaucoma (you or family)		
Dry Eyes/Itching/Burning		Macular Degeneration (you or family)		
Tearing, Redness, Watering		Retinal Detachment (you or family)		
Discharge, Crusting		Soreness/Light sensitivity		
Eyelid Swelling		History of seeing Flashes or Floaters		Remove: Nightly : **Yes/No** Age of current pair_____ Comfortable Yes No
Amblyopia/Patching		History of Amblyopia or Patching		
History of Eye Injury/Surgery		Pain/Visual discomfort		
Please list any drug allergies:				
Please list current medicines:				

Today I am Interested in: ☐ Glasses ☐ Sunglasses ☐ Contact Lenses-Clear/Colored

☐ **Please check here if none of the following apply:**

Mental Status
- ☐ Depression
- ☐ Anxiety
- ☐ Dementia
- ☐ ADD/ADHD

Neurology
- ☐ Stroke/Seizures
- ☐ Concussion/Head injury
- ☐ Paralysis
- ☐ Dizziness
- ☐ Double Vision

Head
- ☐ Hearing Loss
- ☐ Sinus Problems
- ☐ Headaches/Migraines
- ☐ Dry Mouth
- ☐ Seasonal Allergies
- ☐ Trouble sleeping

Genitourinary
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Prostate Problems

Cardiovascular
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ High Blood Pressure

Hematology
- ☐ Anemia/Blood Clotting
- ☐ HIV +
- ☐ Hepatitis _____
- ☐ Sickle Cell/ Trait
- ☐ Cancer/Melanoma
- ☐ Attended Auburn

Musculoskeletal
- ☐ Arthritis
- ☐ Back/Neck Problems

Pulmonary
- ☐ Breathing problems
- ☐ Allergies
- ☐ Tuberculosis
- ☐ Sarcoidosis
- ☐ Lung Disease

Endocrine
- ☐ Diabetes A1C___
- ☐ Thyroid Disease
- ☐ Implant(s)
- ☐ Lupus/MS
- ☐ RA

Gastrointestinal
- ☐ Bowel Problems
- ☐ Liver Disease
- ☐ Gallbladder Disease
- ☐ Pancreatic Disease

Skin
- ☐ Melanoma
- ☐ Shingles/Herpes
- ☐ Oral Acne Treatment
- ☐ Fever Blisters
- ☐ Rosacea

Constitutional/other
- ☐ Fever
- ☐ Weight Change
- ☐ Sleep Apnea

Computer
- ○ Strain
- ○ Tired eyes
- ○ Fatique
- ○ Pain

Contacts
- ○ Sleep in
- ○ Shower in
- ○ Swim in