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SUNSET VALLEY
EYECARE

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contact@sunsetvalleyeye.com

Patient Information

Name: _____
First Middle Last Nickname

Address: _____
Street City State Zip

Date of Birth: _____ Age: _____ SSN: _____ Sex: _____

E-mail: _____ Marital Status: Single / Married / Other

Phone Number: _____
(circle preferred) Home Cell Work

May we contact you for exam reminders? Y / N If yes, preferred method: E-mail / Text / Phone / Other

Occupation: _____ Employer: _____

Date of Last Eye Exam: _____ Name of Last Eye Doctor: _____

Date of Last Medical Exam: _____ Name of Physician: _____

How did you hear about our office? _____

Insurance Information

Vision Insurance Carrier

Name of Carrier: _____ Policy Number: _____

If you are not the primary policy-holder: Group Number: _____

Primary Member's Name: _____ Relationship: Spouse / Parent / Other: _____

Primary's Date of Birth: _____ Primary's SSN: _____

Primary's Address if Different: _____
Street City State Zip

Medical Insurance Carrier (for medical eye conditions/emergencies)

Name of Carrier: _____ Policy Number: _____

Group Number: _____ Supplemental insurance: _____

If you are not the primary policy-holder:

Primary Member's Name: _____ Relationship: Spouse / Parent / Other: _____

Primary's Date of Birth: _____ Primary's SSN: _____

Primary's Address if Different: _____

Street City State Zip

Patient History

Eye Conditions

Have you ever been diagnosed with any of the following?

Cataracts	Yes	No
Macular degeneration	Yes	No
Diabetic eye disease	Yes	No
Retinal detachment	Yes	No
Glaucoma	Yes	No
Floaters	Yes	No
Flashes of light	Yes	No
Dry eyes	Yes	No
Itchy eyes	Yes	No
Watery eyes	Yes	No
Other: _____	Yes	No

Eye Concerns

Do you have any of the following concerns?

Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Watering	Yes	No
Discharge	Yes	No
Blurred vision	Yes	No
Eyestrain	Yes	No
Sensitivity to light	Yes	No
Poor night vision	Yes	No
Eye pain	Yes	No
Double Vision	Yes	No
Other: _____	Yes	No

Current Vision Needs

Do you currently wear glasses?	Yes	No	If so, how often do you wear them? _____
Do you use the computer	Yes	No	If so, how many hours per day? _____
Do you wear contact lenses?	Yes	No	If so, how many hours per day? _____
If not, are you interested in contacts?	Yes	No	Do you sleep in your contacts? Y / N How often? _____
Do you play any sports?	Yes	No	If so, what sports? _____
Do you have any special hobbies?	Yes	No	If so, what are they? _____
Are you interested in LASIK?	Yes	No	

Family Ocular History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

			Relationship to you
Glaucoma	Yes	No	_____
Cataracts	Yes	No	_____
Macular degeneration	Yes	No	_____
Retinal detachment	Yes	No	_____
Crossed or lazy eye	Yes	No	_____
Blindness	Yes	No	_____
Other: _____	Yes	No	_____

Medications

Please list any medications you are currently taking (prescribed and over-the-counter):

_____

_____

_____

Please list any allergies (to medications or other) you have:

_____

_____

Surgical History

Please list any past illnesses of injuries:

_____

_____

Please list any past surgeries (including eye surgery):

_____

_____

Social History

Do you drink alcohol?	Yes	No	If yes, type/amount/how long: _____
Do you smoke cigarettes?	Yes	No	If yes, type/amount/how long: _____
Do you use illegal drugs?	Yes	No	If yes, type/amount/how long: _____

Review of Systems

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

Constitutional

Fever	Yes	No
Fatigue	Yes	No
Weight changes	Yes	No

Skin

Eczema	Yes	No
Rosacea	Yes	No
Psoriasis	Yes	No

Endocrine

Diabetes (Type 1)	Yes	No
Diabetes (Type 2)	Yes	No
Thyroid disease	Yes	No
Hormone dysfunction	Yes	No

Neurological

Headache	Yes	No
Migraines	Yes	No
Seizures	Yes	No
Multiple Sclerosis	Yes	No

Blood/Lymph

Anemia	Yes	No
Bleeding	Yes	No
Leukemia	Yes	No

Genitourinary

Kidney disease	Yes	No
Bladder disease	Yes	No

Gastrointestinal

Ulcers	Yes	No
Crohn's Disease	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No

Respiratory

Asthma	Yes	No
Bronchitis	Yes	No
Emphysema	Yes	No

Ear, Nose, and Throat

Allergy/Hay fever	Yes	No
Cough	Yes	No
Dry throat/mouth	Yes	No
Sinus pressure	Yes	No

Cardiovascular

Heart disease	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No

Musculoskeletal

Fibromyalgia	Yes	No
Muscular Dystrophy	Yes	No
Rheumatoid Arthritis	Yes	No

Psychiatric

Anxiety or Depression	Yes	No

Allergic/Immunologic

Lupus	Yes	No

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

_____

_____

_____

Family Medical History

Please note any family history (parents, grandparents, siblings, children) for the following conditions:

			Relationship to you
Thyroid disease	Yes	No	_____
Diabetes	Yes	No	_____
Cancer	Yes	No	_____
Hypertension	Yes	No	_____
Kidney disease	Yes	No	_____
Lupus	Yes	No	_____
Heart disease	Yes	No	_____
Other: _____	Yes	No	_____