WELCOME TO SHARONVILLE EVENDALE EYECARE

Please bring a list of medications, Photo ID, and all insurance cards to your appointment on: _____ Please complete BOTH sides of this form.

Today's Date _____

Patient Information:

Name: First _____ MI_____ Last _____
Address _____
City _____ State _____ Zip Code _____

Telephone number(s) Rank in the order you would prefer to be contacted:
___Home Phone _____
___Work Phone_____
___Cell Phone _____ Ok to text? _____
___Email Address _____ Ok to email? _____

Date of Birth_____ Age _____ Sex: Male / Female
Right-handed _____ or Left-handed _____
Patient's SSN _____
Marital Status: Married Single Divorced Widow/Widower

Employer (or School): _____
Occupation (or Grade):_____
Spouse's (or Parent's) Name:_____
Spouse's (or Parent's) Employer: _____

Reason for visit today: _____

Any problems with your current:
_____ **Contacts** (if yes, describe):_____
_____ **Glasses** (if yes, describe):_____
_____ **Uncorrected vision** (if yes, describe):_____

Patient Medical History

Name of Family Physician _____Date of Last Physical Check-up_____

CURRENT MEDICATIONS, VITAMINS & SUPPLEMENTS (Rx or Over the Counter) If you have a list we are happy to make a copy for our files.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to medications? ☐ Yes ☐ No If so, what medications? _____

If you are female and of childbearing age, is there a chance you are pregnant? ☐ Yes ☐ No

Do you use: ☐ Cigarettes/Tobacco ☐ Alcohol ☐ Other substances: _____

Have you ever been diagnosed with or treated for the following health problems?

Allergies	?No	?Yes	Genital/Urinary	?No	?Yes
Arthritis	?No	?Yes	High Blood Pressure	?No	?Yes
Blood/Lymph	?No	?Yes	HIV	?No	?Yes
Bronchitis	?No	?Yes	Integumentary (Skin)	?No	?Yes
Cancer	?No	?Yes	Kidney	?No	?Yes
Cardiac/Heart	?No	?Yes	Muscle/Bone	?No	?Yes
Cholesterol	?No	?Yes	Neurological	?No	?Yes
Diabetes	?No	?Yes	Psychological	?No	?Yes
Digestive	?No	?Yes	Respiratory	?No	?Yes
Ears/Nose/Throat	?No	?Yes	Sinus	?No	?Yes
Endocrine	?No	?Yes	Thyroid	?No	?Yes
Eczema/Rashes	?No	?Yes	Weight loss/gain	?No	?Yes
Fatigue	?No	?Yes	? Other_____		
Fevers	?No	?Yes	? Other_____		

Patient Eye History

Date of last eye exam _____ By whom? _____
Have you tried contact lenses? ?Yes ?No
Do you currently wear contact lenses? ?Yes ?No Hours per day_____
What type/brand of contacts? _____
What contact lens solution do you use? _____

Have you ever experienced, been diagnosed or treated for any of the following?

? Blurry Vision ? Burning ? Cataracts ? Corneal Abrasions ? Macular degeneration
? Double Vision ? Eye Infections ? Headaches ? Flashes of light ? Eye injury
? Floaters/Spots ? Glaucoma ? Grittiness ? Retinal detachment ? Iritis/Uveitis
? Itchiness ? Lazy Eye ? Tearing ? Occasional dryness ? Sunlight Sensitivity
? Crossed eye ? Trouble seeing at night Eye surgery types & dates: _____

Family Medical/Eye History Is there a family medical history of any of the following:

(Please mark boxes) Please list relationship and state Mother's or Father's side

Blindness	? _____	Cataracts	? _____
Corneal Problems	? _____	Diabetes	? _____
Glaucoma	? _____	Heart Disease	? _____
Lazy eye	? _____	Macular degeneration	? _____
Retinal detachment	? _____	Hypertension	? _____

Please be sure to give both your vision insurance and major medical insurance information to the front desk staff:
Name of Insurance Company(ies): _____
Insured Name and Date of Birth _____

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I, or stated minor, voluntarily consent to healthcare treatment from the physicians and staff at Sharonville Evendale Eyecare Center. No guarantees have been made regarding the results of treatment or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and operations.

Signature_____