PATIENT INFORMATION UPDATE

Please complete all sections

_____ _____ _____ _____

Last Name **First Name** **Initial** **Suffix**

Date of Birth: _____ **Social Security Number**: __ __ __ – __ __ – __ __ __ __

◆◆◆ **PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO THE FRONT DESK ALONG WITH YOUR ID**

Has your insurance coverage changed since your last visit? ☐ Yes ☐ No _____
Has your address changed since your last visit? ☐ Yes ☐ No _____
Has your contact information changed since your last visit to our office? ☐ No ☐ If yes, please list your new contact information ☐ Phone Number _____ ☐ E-mail _____

◆ **Why are you here today?** _____

◆◆◆ **CURRENT EYE ISSUES:** (please circle all that apply; specify **right** eye, **left** eye or **both**)

Amsler Grid
Blind Spot
Blindness
Blurred Vision
Burning Sensation
Cataract
Central Distortion
Change in Vision
Cobwebs
Color Vision Prob
Diabetic Issues
Difficulty Reading
Dim Vision
Discharge:
- **Pus**
- **Clear**

Distorted Vision
Double Vision
Dry Eyes
Eye Injury
Eye Pain
Foreign Body Sensation in Eye
Flashes of Light
Floaters
Fluctuating Vision
Glaucoma
Halos around Lights
Hard to Read
Hard to See/Do Hobbies
Hazy Central Vision

Headache
Itching
Lid Lesion/Growth
Light Flashes
Loss of Vision
- **Sudden**
- **Gradual**

Macular Degeneration
Migraine
Pain
Poor Night Vision
Rainbows
Redness of Eye
Retinal Detachment
Scratchiness

Sensitivity to Light
Smokey Vision
Straight Lines Wavy
Tearing
Throbbing at Night
Tunnel Vision
Veil or shadow across vision
Visual Field Loss
Watery Eyes
Wavy Lines
Other
_____

◆ **Location of Problem(s): Right Eye, Left Eye or Both Eyes?** _____
◆ **When did you first notice the problem?** _____
◆ **Is the problem/symptom(s) constant or occasional?** _____
◆ **Did the problem appear suddenly or gradually?** _____
◆ **Is the problem/symptom(s) getting better or worse?** _____
◆ **How would you rate the severity of the problem (mild, moderate, severe)?** _____
◆ **Does this problem interfere with your activities?** _____
_____
◆ **Have you ever been treated for this problem?** _____

◆ PERSONAL OCULAR HISTORY

Since your last visit to our office, have you had any changes to your Glasses/Contacts? ☐ Yes ☐ No If yes, please explain: _____

Since your last visit to our office, have you been diagnosed with other eye diseases ☐ Yes ☐ No If yes, please explain _____

Have you ever been diagnosed with malignant melanoma of the eyelid ☐ Yes ☐ No If yes, when were you diagnosed? _____ Doctor: _____

Diabetes ☐ Yes ☐ No **Diabetes Type: _____** What year were you diagnosed with Diabetes? _____
Result/Time of last Blood Sugar:_____ **Last Hemoglobin A1C**: _____ Date Taken _____
Taking Insulin? ☐ Yes ☐ No **Diabetes Treatment**: _____

PCP/Endocrinologist: _____ **Phone**: _____

◆ SOCIAL HISTORY

Smoker? ☐ Yes ☐ No ☐ Formerly **Type?** _____ **How much?** _____ **Year quit** _____
Alcohol Use? ☐ Yes ☐ No ☐ Formerly **Avg Drinks per Day** _____ **Year quit** _____
Drug Use/Abuse? ☐ Yes ☐ No ☐ Formerly **Type?** _____ **Year quit** _____

◆ GENERAL HEALTH REVIEW (please check all those that apply):

Constitutional
☐ Weight Loss
☐ Fever
☐ Nausea/Vomiting
☐ Unusual Fatigue
☐ Pregnant

Cardiovascular
☐ High Blood Pressure
☐ Circulation problems
☐ Cholesterol
☐ Heart Attack

Ear, Nose, Throat
☐ Hearing Loss
☐ Headache/Migraines
☐ Sinus Infection

Endocrine
☐ Diabetes
☐ Thyroid

Gastrointestinal
☐ Acid
☐ GERD
☐ Hepatitis C

Hematologic/Lymphatic
☐ Infection

Immunological/Allergic
☐ Hay Fever
☐ Seasonal Allergies
☐ Lupus

Musculoskeletal
☐ Arthritis
☐ Swelling of Joints

Neurological
☐ Stroke
☐ MS

Respiratory
☐ Asthma
☐ Emphysema
☐ TB

Skin
☐ Eczema
☐ Malignant Melanoma

Since your last visit to our office, have you had surgery? ☐ Yes ☐ No If yes, what type and when? _____
_____

Since your last visit to our office, have you been diagnosed with cancer? ☐ Yes ☐ No What type and when?
_____

Have you had a flu shot this year? ☐ Yes ☐ No If yes, when? _____
If you are over 65, have you ever had a pneumococcal vaccination? ☐ Yes ☐ No When? _____

◆◆◆ MEDICATIONS

Since your last visit to our office, have you started any new Eye Medications?
☐ Yes ☐ No If yes, please list:

Rx: _____ **Reason**: _____ **Dose/Frequency**: _____
Rx: _____ **Reason**: _____ **Dose/Frequency**: _____
Rx: _____ **Reason**: _____ **Dose/Frequency**: _____

Since your last visit to our office, have you started any new prescription medications?
☐ Yes ☐ No If yes, please list:

Rx: _____ **Reason**: _____ **Dose/Frequency**: _____
Rx: _____ **Reason**: _____ **Dose/Frequency**: _____
Rx: _____ **Reason**: _____ **Dose/Frequency**: _____

Since your last visit to our office, have you started any new over-the-counter medications, herbal medications or vitamins? ☐ Yes ☐ No If yes, please list:

Name: _____ **Reason**: _____ **Dose/Frequency**: _____
Name: _____ **Reason**: _____ **Dose/Frequency**: _____
Name: _____ **Reason**: _____ **Dose/Frequency**: _____

◆◆◆ FAMILY HISTORY:

Since your last visit to our office, has anything changed with the health of your family members (including parents, siblings or children)? Pertinent diseases include diabetes, heart disease, high blood pressure, hypertension, hypercholesterolemia, stroke, asthma, cancer, thyroid disease, glaucoma, retinal detachment, amblyopia, macular degeneration, corneal dystrophies and blindness.
☐ Yes ☐ No If yes, please list:
Relationship/Dx: _____
Relationship/Dx: _____

Since your last visit to our office, has a family member passed away? ☐ Yes ☐ No If yes, please specify the relationship, medical problems (if any) and age of death: _____
_____

_____
Signature **Date**

We appreciate your filling out this form today to aid our technicians, optometrists and physicians in caring for you during your visit with us. Thank you for being a patient with Eye Consultants of Maryland.