

WELCOME to GREAT FALLS EYECARE, Optometrists!

Patient Information

Date: _____
 Name: Mr. Mrs. Ms. Dr.
 Last: _____
 First: _____ Middle initial _____
 Address: _____
 City: _____
 State: _____ Zip: _____
 Email: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Birthdate: _____ Sex: M F
 Occupation: _____
 Employer: _____
 How did you hear about us? _____

Insurance Information

Who is responsible for this account? _____
 Relationship to Patient: _____
 Primary Medical Insurance Co.: _____
 Group #/ ID: _____
 Secondary Medical Insurance Co.: _____
 Group #/ ID: _____
 Vision Insurance if separate: _____
 Group #/ ID: _____

I authorize payment of benefits to Great Falls Eyecare. I agree to be financially responsible for any balance not paid by my insurance plan. I authorize the use of my signature on all insurance submissions. Sign: _____
 Date: _____

Eye Health History

Date of last eye exam: _____
 Do you wear glasses? YES NO
 If so when do you wear them? _____
 Do you wear contacts? YES NO
 If so, type? _____
 And hours/day? _____
 Have you had eye surgery? YES NO
 If so, type and date? _____
 Are you using ANY kind of eye drops?
 YES NO
 If so, type? _____

Place a mark on "Yes" or "No" if you have had the following:

Burning eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision- Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision- Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Redness in Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision, poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Eye infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Side Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family Health History

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

Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to you:

** Please turn this form over and complete side two **

Social History: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with my doctor. (check box)

Are you pregnant or nursing? Yes No

Do you drive? Yes No

If yes, then do you have visual difficulty when driving? Yes No If yes, please describe: _____

Do you use tobacco products? Yes No If yes, type/ amount/ how long: _____

Do you drink alcohol? Yes No If yes, type/ amount/ how long: _____

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

Have you ever been exposed to or infected with Gonorrhea Hepatitis HIV Syphilis

Review of Systems: Do you currently, or have you ever had any problems in the following areas:

Constitutional	Yes	No	?	Ears, Nose, Mouth, Throat	Yes	No	?
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/ Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Vascular / Cardiovascular			
Thyroid/ other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bones/ Joints/ Muscles				Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphatic/ Hematologic				Gastrointestinal			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital/ Kidney/ Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Doctor's Signature

Date