Excel Eyecare Optometry

Patient Information ☐ No Change

Last Name _____ First Name _____ Middle Name _____

Last 4 SSN _____ Birthdate _____ Sex ☐ M ☐ F Marital status ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Home Address _____ City _____ State _____ Zip _____

E-mail _____ Home Phone _____ Mobil Phone _____

Employer _____ Occupation _____ Work Phone _____

Emergency contact _____ Phone _____ Referred by _____

Insurance Information ☐ No Change

Insurance Name	Member ID	Group #	Insured's Name	Insured's DOB	Relation to patient

Patient Medical History ☐ No Change

1. Date of last physical exam _____ Personal physician _____
2. Date of last eye exam _____ Doctor _____
3. Do you wear glasses? No If yes, age of present glasses _____ contact lens? No If yes, type _____
4. Do you have? (please circle yes or no)

Eye strain	No	Dry eyes	No	Floaters	No	Flashes of light	No	Macular degeneration	No
Eye pain	No	Itchy eyes	No	Double vision	No	Blurred vision	No	Severe or frequent headaches	No

5. Do you or any blood relatives have? (please circle yes or no)

	Self	Relative		Self	Relative		Self	Relative
Cataracts	No	No	Color blindness	No	No	Retinal disease	No	No
Glaucoma	No	No	Blindness or poor night vision	No	No	High blood pressure	No	No
Diabetes	No	No	Crossed or wall eyes	No	No	High cholesterol	No	No

6. Are you being treated for any medical condition? No If yes, please list _____
7. Are you taking any medications? No If yes, please list _____
8. Are you allergic to any medication including eye drops? No If yes, please list _____
9. Do you have or have you ever had any eye disease, injury or surgery? No If yes, please explain _____
10. Do you have problems with these systems? (please circle yes or no)

Gastrointestinal	No	Nervous	No	Endocrine (glands)	No	Cardiovascular	No	Muscles / Bones	No
Ears/Nose/Throat	No	Urinary	No	Blood / Lymph	No	Respiratory	No	Integumentary (skin)	No

If yes to any, please explain _____

11. Do you drink? No If yes, how often _____ smoke? No If yes, how often _____
12. Have you ever used drug? No If yes, please list _____

The information I have provide above is accurate and complete to the best of my knowledge. I authorize the release of any medical or other information necessary to process the insurance claim. I also authorize payment of my insurance benefits to Excel Eyecare Optometry for the service I have received. If under 18 years of age, parent signature required.

Patient Signature _____ Date _____

Doctor Use Only

Reviewed by doctor **Michelle A. Gan, OD** Signature _____ Date _____