Excel Eyecare Optometry

Patient Information ☐ No Change

Last Name _____ First Name _____ MI ___ Date _____

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? Yes No If yes, age of present glasses _____ contact lens? Yes No If yes, type _____
4. Do you have? (please circle yes or no)

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

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

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

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

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

If yes to any, please explain _____

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