PARKWAY eyecare

Exam Date: ___/___/___

PATIENT INFORMATION

Last Name: _____ First Name: _____ ☐ M ☐ F Birth Date: ___/___/___

Address: _____ City: _____ State: ____ Zip Code: _____

Phone: _____ home/work/cell *(circle one)* Email: _____

Occupation: _____ Employer/School: _____

How did you hear about us? _____

INSURANCE INFORMATION

Vision Insurance: _____

ID# (if any): _____

Primary Name: _____

Primary's Last 4 SSN: _____

Primary Birth Date: ____/____/____

Patient's relation to Primary: ☐ Self ☐ Spouse ☐ Child

Medical Insurance: _____

ID#: _____ Group#: _____

Primary Name: _____

Primary Last 4 SSN: _____

Primary Birth Date: ____/____/____

Patient's relation to Primary: ☐ Self ☐ Spouse ☐ Child

CURRENT EYE CONCERNS

Please **check** all that apply to you (the patient)

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Blurred Vision
- ☐ Eyestrain
- ☐ Eye Pain
- ☐ Severe sensitivity to light
- ☐ Headache
- ☐ Poor night vision
- ☐ Bothersome night glare
- ☐ Double vision
- ☐ Total loss of vision
- ☐ Other: _____ _____

OCULAR & MEDICAL HISTORY

Please check the box for **yourself** (the patient) or for any **blood relatives** when applicable (i.e. grandparents, parents, siblings, cousins).

Self	None	
☐	☐	Dry Eye
☐	☐	Eye Infection
☐	☐	Ocular Allergies
☐	☐	Floaters/Flashes of light
☐	☐	Iritis or Uveitis
☐	☐	Eye Injury

Self	Rel.	None	
☐	☐	☐	Cancer: _____
☐	☐	☐	Diabetes type 1
☐	☐	☐	Diabetes type 2
☐	☐	☐	Hypertension
☐	☐	☐	Hypothyroidism
☐	☐	☐	Hyperthyroidism

Self	Rel.	None	
☐	☐	☐	Cataract
☐	☐	☐	Macular Degeneration
☐	☐	☐	Glaucoma
☐	☐	☐	Retinal Detachment

PLEASE SEE BACK

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PARKWAY eyecare

REVIEW OF SYSTEMS

Please **circle** all that apply to you (the patient).

Constitution
- Developmental Disabilities
- Cancer
- Fatigue Syndrome

ENT (Ear, Nose, Throat)
- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis

Neurological
- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine
- Autism Spectrum Disorder

Psychiatric
- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder

Cardiovascular
- Hypertension
- Heart Disease
- Vascular Disease
- Congestive Heart Failure

Respiratory
- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea

GI (Gastrointestinal)
- Crohn's
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease

GE (Genitourinary)
- Kidney disease
- Prostate disease/cancer
- STD – herpetic/chlamydia
- Benign Prostate Hypertrophy
- Pregnant
- Nursing

Musculoskeletal
- Osteoarthritis
- Arthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout

Integumentary
- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles

Endocrine
- Diabetes Type 1
- Diabetes Type 2
- Thyroid Dysfunction
- Hormonal Dysfunction

Hematologic/Lymphatic
- Anemia
- Large-volume blood loss
- Ulcer
- Hypercholesteremia

Immune
- Rheumatoid Arthritis
- Lupus
- Sjogren's Syndrome

Additional Comments about the conditions above: _____

_____

Are you taking any medications? Please list: _____

_____

_____

_____

Do you have any allergies (**medication** or other)? If yes, please list: _____

_____

Smoke: □No □Yes, amount daily _____

Alcohol Consumption: □No □Yes (*circle one)*: daily/ occasionally/ rarely

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