

KEYSTONE EYE ASSOCIATES

PATIENT INFORMATION

DATE: _____

Please complete **ALL** information requested **on both sides**. **Please bring all Insurance Information with you on the day of your visit.**

LAST NAME: _____ **FIRST NAME:** _____

Marital Status: Single Widowed Married Spouses Name: _____

Home Address: _____

City _____ State _____ Zip Code _____ Home Phone _____

E-Mail: _____

INSURANCE: Plan: _____ ID#: _____

OCCUPATION: _____ Work Phone: _____

Employer: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #** _____

Whom May We Thank For Referring You To Us? _____

EMERGENCY CONTACT? _____ Phone # _____

Who Is Your Medical Doctor? _____ Phone # _____

SOCIAL HISTORY:

Do you drive? Yes No

Do you smoke? Yes No Packs per day? _____ How long? _____

Do you drink alcohol? Yes No

Do you presently exercise: Yes No

FAMILY HISTORY:

Does any **BLOOD RELATIVE** have any of the following:

Y N Diabetes Who? _____

Y N Glaucoma Who? _____

Y N Macular Degeneration Who? _____

Y N Amblyopia (Lazy Eye) Who? _____

Y N Retinal Detachment Who? _____

Y N High Blood Pressure Who? _____

Y N Heart Disease Who? _____

Y N Strokes/Neurological Disease Who? _____

Y N Cancer Who? _____

Y N Respiratory Disease Who? _____

Do you have any **ALLERGIES?** Seasonal? Y N
 Latex Y N
 Drug/Other? Y N _____

Please list **ALL MEDICATIONS** you currently take: _____

PATIENT MEDICAL HISTORY:

Do **YOU** have any of the following **medical** problems (please check yes or no):

- | | | | | | |
|----------------------------|----------------------------|---------------------|----------------------------|----------------------------|-------------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | High Blood Pressure | <input type="checkbox"/> Y | <input type="checkbox"/> N | Arthritis/Joint Disease |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y | <input type="checkbox"/> N | Migraines |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Depression/Anxiety |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y | <input type="checkbox"/> N | Shingles |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma/Emphysema | <input type="checkbox"/> Y | <input type="checkbox"/> N | Thyroid |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Stomach Disorders | <input type="checkbox"/> Y | <input type="checkbox"/> N | Sinus Infections |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Kidney Disease | <input type="checkbox"/> Y | <input type="checkbox"/> N | Hard of Hearing |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Neurologic/-strokes | <input type="checkbox"/> Y | <input type="checkbox"/> N | Cholesterol |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Blood Disorders | <input type="checkbox"/> Y | <input type="checkbox"/> N | Skin Disorders |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Frequent Fatigue | <input type="checkbox"/> Y | <input type="checkbox"/> N | Weight loss/gain |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Sleep Apnea | <input type="checkbox"/> Y | <input type="checkbox"/> N | Pacemaker/Defibulator |

Other: _____

PATIENT OCULAR HISTORY:

Date of **LAST EYE EXAM:** _____

Please list any previous **EYE SURGERIES/LASERS:** (type and which eye) _____

Please list any and all **EYE DROPS OR EYE MEDICATIONS** you are currently using:

<u>Medication</u>	<u>Which Eye?</u>	<u>How many times per day?</u>

Have **YOU** ever been diagnosed with any of the following eye problems:

- | | | | | | |
|----------------------------|----------------------------|----------------------|----------------------------|----------------------------|---------------------------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Glaucoma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Blurred/Double/Distorted Vision |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Macula Degeneration | <input type="checkbox"/> Y | <input type="checkbox"/> N | Flashes/Floaters |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Dry Eyes | <input type="checkbox"/> Y | <input type="checkbox"/> N | Glare or Light Sensitivity |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Retinal Detachment | <input type="checkbox"/> Y | <input type="checkbox"/> N | Redness/Itching/Burning/Tearing |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cataracts | <input type="checkbox"/> Y | <input type="checkbox"/> N | Eye pain |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetic Retinopathy | <input type="checkbox"/> Y | <input type="checkbox"/> N | Foreign Body Sensation |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Lazy Eye | <input type="checkbox"/> Y | <input type="checkbox"/> N | Chronic Eye/Eyelid Infections |

Thank you for taking the time to answer our questions. Though some questions may seem to be unrelated to an eye exam, many diseases can be detected through an eye exam and some medications can affect your vision.