ELLIOTT EYE
DOCTORS

Office Use Only
Date:_____
Data Entered By_____
Pretesting By _____
ID#_____

Welcome to Elliott Eye Doctors!

Thank you for choosing Elliott Eye Doctors! The following information is used to provide you with the highest quality of care and all questions are relevant to your examination. Some insurance companies require information to be asked at each visit, so please answer to the best of your ability and ☑check all boxes that apply. A paper copy can be provided per request. If you have any questions or need assistance feel free to ask one of our staff members, we are happy to help! ☺

Name (Last, First) _____Birth Date:_____ Social Security#_____

What brings you in today? _____

Do you have any questions for the Doctor? _____

_____

Date of Last Eye Exam: _____ By Dr. _____

Date of Last Physical Exam: _____ Primary Care Physician:_____

Location: _____ Phone Number:_____

Eyewear and Contact Lenses

Do you wear eyeglasses? □No □Distance □Reading □Progressive □Bifocal □Computer □Other

Do you wear contact lenses? □YES □NO Brand?_____

Prescription? Right Eye_____ Left Eye_____

How old is your current pair of contact lenses?_____ How many contact lenses do you have left? _____

Today's Wearing Time? _____ Average Daily Wearing Time? _____ Average Replacement Period? _____

How often do you sleep in your lenses? _____Solution Used?_____ Drops Used?_____

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Do you currently have any of the following eye concerns? (☑Check all that apply)

□Blurred Vision □Redness □Mucous Discharge □Foreign Body Sensation
□Distorted Vision/Halos □Burning □Sandy or Gritty Feeling □Chronic Lid Infection
□Loss of Side Vision □Itching □Glare/Light Sensitivity □Eye Pain or Soreness
□Loss of Central Vision □Dryness □Swelling □Crusting on Eyelashes
□Flashes/Floating □Spots □Double Vision □Watering/Tearing
Other:_____

Have you been diagnosed with any of the following conditions? (☑Check all that apply)

□Choroidal Melanoma □Cataracts □Glaucoma □Farsightedness
□Night Blindness □Dry Eye □Lazy Eye □Near Sightedness
□Retinal Detachment □Blindness □Astigmatism □Presbyopia
□Nystagmus □Retinitis Pigmentosa □Corneal Ulcer □Macular Degeneration
□Diabetic Retinopathy □Iritis □Floaters □Keratoconus

Other:_____

Have you had any of the following procedures or correction for the following conditions?

□Keratoconus □Glaucoma □Cataract □Macular Degeneration
□Injections □Laser □Nystagmus □Corneal Transplant
□Eye Injury □Botox □Punctal Occlusion □Eye Muscle Surgery
□Retinal Hole/Detachment □Patching or Vision Therapy

Other:_____

Medical History

Do you have any of the following health conditions? (☑Check all that apply)

Constitutional:	□Fibromyalgia	□Depression	□Attention Deficit	□Anxiety	□Bipolar
Neurological:	□**Headache/Migraine**	□Stroke	□Multiple Sclerosis	□Autism	□Seizures
Respiratory:	□Chronic Bronchitis	□Asthma	□Emphysema	□Sleep Apnea	□COPD
ENT:	□Hearing loss	□Sinusitis	□Dry Mouth	□Laryngitis	
Gastrointestinal:	□Crohn's Disease	□Colitis	□Celiac Disease	□Acid Reflux	□Ulcer
Genitourinary:	□Chlamydia	□Herpes	□Prostate Cancer	□Kidney Disease	
Cardiovascular:	□Stroke	□Heart Disease	□**Hypertension**	□Congestive Heart Failure	
Musculoskeletal:	□Arthritis	□Osteoporosis	□Gout	□Ankylosing Spondylitis	
Integumentary:	□Eczema	□Rosacea	□Psoriasis	□Acne	
	□ Herpes Simplex (Cold Sores)		□Herpes Zoster (Shingles)		
Blood Disorders:	□Anemia	□Blood Loss	□**High Cholesterol**		
Immune:	□Lupus	□HIV/AIDS	□Sjogren's Syndrome	□Rheumatoid Arthritis	
Endocrine:	□**Type I Diabetes***	□**Type II Diabetes***	□Thyroid Dysfunction	□Hormone Dysfunction	

*Date you were diagnosed with diabetes mellitus? _____Last HbA1c?_____ Date:_____

Last blood sugar level?_____ Time: _____ Do you feel your diabetes is under control? □YES □NO

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Are you currently taking any medications? □YES □NO Please list: _____

_____

_____

_____

Do you have any known medication allergies? □YES □NO _____

_____

Do you have any known environmental or seasonal allergies? □YES □NO _____

_____

Have you had any major surgeries in your lifetime? □YES □NO Please List:_____

_____

_____

_____

Social History

What is your occupation? _____

What are your hobbies? _____

Do you drive? □YES □NO Do you consume alcohol? □YES □NO

Are you pregnant and/or breast-feeding? □YES □NO

Do you use tobacco products? □No □Cigarettes □Cigars □Chewing Tobacco

Quantity and How Frequently?_____

If former smoker, how long ago did you quit?_____

Marital/Living Status: □Single □Married □Separated □Divorced □Widowed

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Family History

Please provide your immediate family history below by checking or circling all that apply.

(M- Mother, F- Father, B-Brother, S-Sister, MGM- Maternal Grandmother, MGF- Maternal Grandfather, PGM- Paternal Grandmother, PGF- Paternal Grandfather)

Osteoarthritis	M	F	B	S	MGM	MGF	PGM	PGF
Asthma	M	F	B	S	MGM	MGF	PGM	PGF
Thyroid Disorders	M	F	B	S	MGM	MGF	PGM	PGF
Cancer	M	F	B	S	MGM	MGF	PGM	PGF
Type 1 Diabetes	M	F	B	S	MGM	MGF	PGM	PGF
Type 2 Diabetes	M	F	B	S	MGM	MGF	PGM	PGF
Hypertension	M	F	B	S	MGM	MGF	PGM	PGF
Heart Disease	M	F	B	S	MGM	MGF	PGM	PGF
High Cholesterol	M	F	B	S	MGM	MGF	PGM	PGF
Rheumatoid Arthritis	M	F	B	S	MGM	MGF	PGM	PGF
Stroke	M	F	B	S	MGM	MGF	PGM	PGF
Amblyopia	M	F	B	S	MGM	MGF	PGM	PGF
Color Blindness	M	F	B	S	MGM	MGF	PGM	PGF
Cataract	M	F	B	S	MGM	MGF	PGM	PGF
Macular Degeneration	M	F	B	S	MGM	MGF	PGM	PGF
Glaucoma	M	F	B	S	MGM	MGF	PGM	PGF
Retinal Detachment	M	F	B	S	MGM	MGF	PGM	PGF
Strabismus	M	F	B	S	MGM	MGF	PGM	PGF

By signing below I authorize all information provided has been answered to the best of my ability and I will contact Elliott Eye Doctors to provide them with any updates or changes.

Patient Signature_____Date:_____

Parent/Guardian Signature_____ Date:_____