SAN PEDRO
EYE CARE

Patient Form

General Information

First Name, Last Name, MI, Preferred Name
Street Address
City, State, Zip
Phone, Type
Phone 2, Type
Email
Preferred Contact Method *cell phone* | *home phone* | *email*
Patient Social Security Number
Date of Birth
Male/Female
Occupation/Employer *full time* | *part time*
Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*
Language, Race, Ethnicity
Emergency Contact Person and Phone
Mother's Maiden Name
Who Referred You to Our Office
Pharmacy
Primary Care Physician

Insurance Information

Vision Insurance
Vision Insurance Member Name
Vision Insurance Member ID #
Vision Insurance Member Date of Birth
Primary Medical Insurance
Primary Member Name
Insurance ID #
Insurance Policy #/Group ID#
Primary Member Date of Birth
Primary Member Social Security Number
Primary Member Employer
Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

SAN PEDRO EYE CARE

Patient Form

Eye History

Date of Last Eye Exam
Currently Wear?
Currently Wear Contact?
Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or PRK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

☐ Blurry Vision	*near*	*distance*
☐ Burning		
☐ Discharge		
☐ Double Vision		
☐ Dryness		
☐ Excess Tearing/Watering		
☐ Eye Infection		
☐ Eye Pain or Soreness		
☐ Floater or Spots		
☐ Halos		
☐ Headaches		
☐ Itching		
☐ Light Flashes		
☐ Light Sensitivity		
☐ Redness		
☐ Sandy or Gritty Feeling		

Medical History

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ear, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Discorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter dosage)

Medication Drug Allergies

Height **Weight**
Are you pregnant or nursing?
Do you smoke?
Have you ever smoked?