



Welcome to Primary Eyecare Professionals

Patient Information

Name _____
Address _____ City _____ State _____ Zip Code _____
Telephone –Home _____ Work _____ Cell _____
Head of Household E-Mail Address _____
Date of Birth _____ Social Security # _____ Student- Y/N Married- Y/N
Employer _____ Occupation _____
Reason for visit _____

Insured's Information

Name of Insured _____ Relationship to Pt. _____
Insured's SS# _____ Insured's Date of Birth _____

Personal Eye Information

Do you wear glasses? Y/N Do you have a Bifocal or Multifocal? Y/N
Do you wear contact lenses? Y/N Do you wear Soft or Rigid lenses? _____
Have you had any eye operations? Y/N Type _____ Date _____
Have you had any eye injuries? Y/N Type _____ Date _____
Have you been diagnosed with glaucoma? Y/N Cataracts Y/N Macular Degeneration Y/N
Do you have?: Dry Eyes-Y/N Blurred vision-Y/N Night Blindness-Y/N
Any other eye problems? _____

Family History

Blood pressure-Y/N Relation _____ Macular Degeneration-Y/N Relation _____
Diabetes-Y/N Relation _____ Retinal Detachment-Y/N Relation _____
Glaucoma-Y/N Relation _____ Cataracts-Y/N Relation _____
Other eye condition(s)-Y/N-What kind & Relation _____

Medical Information

Do you have problems with any of these systems? (please circle all that apply)
Gastrointestinal-Y/N Nervous-Y/N Mental-Y/N
Ears/Nose/Throat-Y/N Genitourinary-Y/N Endocrine (glands)-Y/N
Cardiovascular-Y/N Musculoskeletal-Y/N Blood/Lymph-Y/N
Respiratory-Y/N Integumentary (skin)-Y/N Allergic/Immunologic-Y/N
Please explain any circled yes _____
Please circle all that apply:
Diabetes-Y/N Type _____ Date of First Diagnosis _____
Allergies-Y/N Type _____ Medication Allergies-Y/N Type _____
Headaches-Y/N Frequency? _____ Location? _____ Relief? _____
Medications- _____

Whom may we thank for referring you? _____