



WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING

Today's Date: ____/____/____

PATIENT INFORMATION				
LAST NAME	MR MS MISS DR	FIRST NAME	MIDDLE	DATE OF BIRTH
HOME ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE	WORK OR CELL PHONE	EMAIL ADDRESS		
EMPLOYER (OR SCHOOL)	OCCUPATION (OR GRADE)	HOBBIES/SPECIAL INTERESTS		
HOW DID YOU HEAR ABOUT OUR OFFICE				
<input type="checkbox"/> INSURANCE <input type="checkbox"/> PHONE BOOK <input type="checkbox"/> MAILING AD <input type="checkbox"/> LOCATION <input type="checkbox"/> INTERNET <input type="checkbox"/> REFERRAL		WHOM MAY WE THANK FOR REFERRING YOU?		
IF THE PATIENT IS UNDER 18 YEARS OF AGE				
NAME OF PARENT/GUARDIAN		HOME OR CELL PHONE	RELATION TO PATIENT	
EMERGENCY CONTACT				
NAME OF EMERGENCY CONTACT		HOME OR CELL PHONE	RELATION TO PATIENT	
MEDICAL INFORMATION				
PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR	DATE OF LAST EYE EXAM	
MEDICAL INSURANCE COVERAGE				
NAME OF MEDICAL INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE	RELATION TO PATIENT	
VISION INSURANCE COVERAGE				
NAME OF VISION INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE	RELATION TO PATIENT	

DIGITAL RETINAL IMAGING

Clearview Eye Care believes that using the best technology is crucial to maintaining good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Imaging or Photography, which produces a high definition picture of your retina, interior blood vessels, and optic nerves. These images are vital in helping Dr. Beach assess your risks for serious ocular disease. The imaging also serves as a very important baseline, so every year your eyes can be compared to past images to monitor for even the smallest changes. Dr. Beach strongly recommends retinal photos every 12 months for every patient.

- Yes, I would like to have Digital Retinal Imaging performed today (additional fee of \$39)
- No, contrary to Dr. Beach's recommendation, I am refusing retinal photos and understand the health risks involved.

Patient/Guardian Signature _____ DATE _____

DO YOU CURRENTLY:		ARE YOU INTERESTED TODAY IN:	
<input type="checkbox"/> WEAR GLASSES IF SO, HOW OLD ARE THEY: _____ <input type="checkbox"/> WEAR POLARIZED SUNGLASSES IF SO, HOW OLD ARE THEY: _____ <input type="checkbox"/> WEAR CONTACT LENSES IF SO, WHAT BRAND: _____		<input type="checkbox"/> PURCHASING NEW EYEWEAR <input type="checkbox"/> TRYING CONTACT LENSES <input type="checkbox"/> LEARNING ABOUT REFRACTIVE SURGERY	
YOUR VISUAL FUNCTION: Please check all that apply to you			
<input type="checkbox"/> WORK ON COMPUTERS UNDER FLOURESCENT LIGHTING <input type="checkbox"/> SPEND TIME PLAYING OUTDOOR ACTIVITIES <input type="checkbox"/> ENJOY BOATING OR OTHER WATER SPORTS <input type="checkbox"/> EYES ARE SENSITIVE TO SUNLIGHT <input type="checkbox"/> DRIVE TO OR FROM WORK DIRECTLY FACING THE SUN <input type="checkbox"/> OCCUPATION INVOLVES POSSIBILITY OF EYE INJURY		<input type="checkbox"/> CONTACT LENSES GET DRY AT LEAST ONCE A DAY <input type="checkbox"/> CONTACT LENSES ARE NOT AS CLEAR AS DESIRED <input type="checkbox"/> EXPERIENCE GLARE WHILE DRIVING AT NIGHT <input type="checkbox"/> EXPERIENCE EYE STRAIN WHILE USING THE COMPUTER <input type="checkbox"/> READ BOOKS/STUDY FOR LONGER THAN 2 HOURS A DAY <input type="checkbox"/> WOULD LIKE INFO ON THINNER/LIGHTER LENSES	
HAVE YOU EVER HAD:			
<input type="checkbox"/> CATARACT SURGERY <input type="checkbox"/> EYE MUSCLE SURGERY <input type="checkbox"/> RETINAL SURGERY <input type="checkbox"/> LASIK SURGERY <input type="checkbox"/> OTHER EYE SURGERY IF SO, WHICH EYE _____ WHEN _____			
DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING			
<input type="checkbox"/> BLURRED VISION <input type="checkbox"/> DRYNESS <input type="checkbox"/> FLOATERS IN VISION <input type="checkbox"/> SANDY FEELING <input type="checkbox"/> BURNING <input type="checkbox"/> EXCESSIVE TEARING <input type="checkbox"/> GLARE SENSITIVITY <input type="checkbox"/> SUDDEN VISION LOSS <input type="checkbox"/> DOUBLE VISION <input type="checkbox"/> EYE PAIN/SORENESS <input type="checkbox"/> EYE/EYELID INFECTION <input type="checkbox"/> LOSS OF SIDE VISION <input type="checkbox"/> DROOPING EYELID <input type="checkbox"/> FLASHES OF LIGHT <input type="checkbox"/> ITCHING <input type="checkbox"/> OTHER			
VISION HISTORY		MEDICAL HISTORY	
Check appropriate boxes if YOU or your blood RELATIVES have:		Check appropriate boxes if YOU or your blood RELATIVES have:	
F = father M = mother S = brother/sister GP = grandparent(s)		F = father M = mother S = brother/sister GP = grandparent(s)	
	<u>YOU</u>	<u>FAMILY MEMBER</u>	
		F M S GP	<u>YOU</u>
Amlybopia/lazy eye	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Color blindness	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Crossed/turned eyes	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Diabetic retinopathy	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Herpes eye disease	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Keratoconus	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Retinal detachment	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Traumatic eye injury	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
Other eye condition	<input type="checkbox"/>	F M S GP	<input type="checkbox"/>
SOCIAL HISTORY		Allergies	
Do you smoke?	NO YES _____ pack per day	<input type="checkbox"/>	
Alcohol use?	NO YES _____ drinks per week	<input type="checkbox"/>	
FEMALES: ARE YOU		Arthritis	
<input type="checkbox"/> PREGNANT _____ MONTHS <input type="checkbox"/> NURSING		<input type="checkbox"/>	
PLEASE LIST ALL CURRENT MEDICATIONS		Blood disease (anemia)	
		<input type="checkbox"/>	
		Breathing problems	
		<input type="checkbox"/>	
		Cancer	
		<input type="checkbox"/>	
		Cardio (heart,carotid)	
		<input type="checkbox"/>	
		Cholesterol, high	
		<input type="checkbox"/>	
		Collagen (lupus)	
		<input type="checkbox"/>	
		Diabetes	
		<input type="checkbox"/>	
		Fatigue	
		<input type="checkbox"/>	
Fever blister/cold sore			
<input type="checkbox"/>			
Gastro (stomach,colon)			
<input type="checkbox"/>			
Genital,kidney,bladder			
<input type="checkbox"/>			
Headache/migraine			
<input type="checkbox"/>			
Hearing impairment			
<input type="checkbox"/>			
Herpes simplex/zoster			
<input type="checkbox"/>			
High blood pressure			
<input type="checkbox"/>			
HIV, AIDS			
<input type="checkbox"/>			
Hormonal/thyroid			
<input type="checkbox"/>			
Immunologic disease			
<input type="checkbox"/>			
Muscle, bone, joint			
<input type="checkbox"/>			
Neurologic, MS			
<input type="checkbox"/>			
Nose, Sinus, Throat			
<input type="checkbox"/>			
Psych (anxiety,depression)			
<input type="checkbox"/>			
Resp (asthma,emphysema)			
<input type="checkbox"/>			
Sex. transmitted disease			
<input type="checkbox"/>			
Skin (acne, eczema)			
<input type="checkbox"/>			
Weak/numb arm or leg			
<input type="checkbox"/>			
Weight changes,sudden			
<input type="checkbox"/>			
PLEASE LIST ALL ALLERGIES, INCLUDING DRUG ALLERGIES			