ALTITUDE EYE CARE

TODAY'S DATE: _____/_____/_____

PATIENT'S INFORMATION: (Please present photo identification along with this form)

Last Name: _____First Name:_____M.I.:_____Birthdate:_____/_____/_____

Address:_____City_____State_____Zip_____

Home Phone: (_____)_____-_____ Work: (_____)_____-_____ Mobile:(_____)_____-_____

May we text you reminders & order status updates? ❍Yes ❍No May we leave a voice message if needed? ❍Yes ❍No

E-Mail Address:_____ May we e-mail reminders and order status updates? ❍Yes ❍No

Preferred method of contact: ❍Home Phone ❍Work Phone ❍Cell Phone ❍Text ❍E-Mail

Gender: ❍Male ❍Female Social Security# :_____ Marital Status: ❍Married ❍Single ❍Widowed ❍Other

Employer:_____ Occupation:_____❍Full time ❍Part Time ❍Student ❍Retired

Ethnicity:❍Hispanic/Latino ❍Pacific Islander ❍Not Hispanic or Latino **Race:**_____ **Pref'd Language**:_____

PERSON RESPONSIBLE FOR PATIENT'S PAYMENT

Last Name: _____ First Name: _____ M.I.:_____ Birthdate: _____/_____/____

Address:_____City_____State_____Zip_____

Home #:(_____)_____-_____ Cell #:(_____)_____-_____ Work #: (_____)_____-_____

Social Security #:_____ Gender: ❍Male ❍Female Relationship to Patient : ❍ Self ❍ Spouse ❍ Parent/Guardian

VISION PLAN NAME: _____ (Please present insurance card along with this form)

Primary Insured's Name: _____ Birthdate: _____/_____/_____

Address:_____City_____State_____Zip_____

Insured's Home #:(_____)_____-_____ Cell #:(_____)_____-_____ Work #: (_____)_____-_____

Employer:_____ Social Security #:_____ Gender: ❍ Male ❍ Female

Member ID: _____ Group#:_____ Relationship to Patient:❍ Self ❍ Spouse ❍ Parent/Guardia

MEDICAL PLAN NAME: _____ (Please present insurance card along with this form)

Primary Insured's Name: _____ Birthdate: _____/_____/_____

Address:_____City_____State_____Zip_____

Insured's Home #:(_____)_____-_____ Cell #:(_____)_____-_____ Work #: (_____)_____-_____

Employer:_____ Social Security #:_____ Gender: ❍ Male ❍ Female

Member ID: _____ Group#:_____Relationship to Patient: ❍ Self ❍ Spouse ❍ Parent

*Primary Care Doctor (Name/Addr/Phone/Fax):_____

*Primary Pharmacy (Name/Addr/Phone):_____

OFFICE USE ONLY BELOW: Patient ID: _____ **NEW / EXIST**

CO-PAYS: Vision: _____ Medical:_____RV? Y / N FIT:_____/ No Cov CL's: _____

TIME:_____/ WIB DR: KN / CN / AD / ZL / JG ❍ GLXM ❍ CLXM (PW / NW / ?) ❍ FIT ONLY ❍ OV ❍ OCT ❍ IOP

\+ / - Butterfly _____/_____ IOP ____/ 7 COLOR **ALERTS:** ❍ IOP ❍ OPD ❍ VF ❍ OPTOS/CLARUS ❍ OCT

Last Name:_____ First Name:_____Birthdate:_____/_____/_____Today's date:_____/_____/_____

REASON FOR *TODAY'S* VISIT (Check all that apply):

❍Blurred Vision: ❍Distance ❍Intermediate ❍Near
❍Eye irritation/discomfort
❍Other symptoms related to *today's* visit: _____
_____

Do you wear glasses?

❍Yes: ❍Distance ❍Near ❍Computer / ❍Full time ❍Part time
❍No, I have never worn glasses.
❍Not currently, but I have worn glasses in the past.

Do you wear contact lenses?

❍Yes. Brand/powers: _____
Do you intentionally sleep in them? ❍Yes: ____nights/week ❍No
❍No, I have never worn contacts.
❍Not currently, but I have worn contacts in the past.
❍If you do *not* wear contact lenses, are you interested? ❍Yes ❍No

DATE/PROVIDER LAST EYE EXAM: _____

OCULAR HISTORY	Self:	Family (list relation):
Cataracts	❍Yes ❍No	❍_____
Glaucoma	❍Yes ❍No	❍_____
Retinal Hole/Tear	❍Yes ❍No	❍_____
Retina Detached	❍Yes ❍No	❍_____
Dry Eye Syndrome	❍Yes ❍No	❍_____
Strabismus	❍Yes ❍No	❍_____
Amblyopia	❍Yes ❍No	❍_____
Floaters	❍Yes ❍No	❍_____
Flashes of Light	❍Yes ❍No	❍_____

Other (*including surgeries*): _____
_____

MEDICAL HISTORY & REVIEW OF SYSTEMS

DATE OF LAST PHYSICAL:_____

ALLERGIES: ❍None ❍Yes (give substance/reaction i.e.Penicillin/Hives):
_____

MEDICATIONS: ❍None ❍Yes (List all, including dosage and frequency):
_____
_____
_____

CARDIOVASCULAR	Self:	Family (list relation):
Cardiovascular Disease	❍Yes ❍No	❍_____
Elevated Cholesterol	❍Yes ❍No	❍_____
Hypertension	❍Yes ❍No	❍_____

Other: _____

CONSTITUTIONAL	Self:	Family (list relation):
Fatigue (chronic)	❍Yes ❍No	❍_____

Other:_____

ENDOCRINE	Self:	Family (list relation):
Diabetes Mellitus Type I	❍Yes ❍No	❍_____
Diabetes Mellitus Type II	❍Yes ❍No	❍_____
Hyperthyroidism	❍Yes ❍No	❍_____

Other: _____

GASTROINTESTINAL	Self:	Family (list relation):
Acid Reflux	❍Yes ❍No	❍_____
Cancer: Colon	❍Yes ❍No	❍_____

Other: _____

(Continued)

GENITOURINARY	Self:	Family (list relation):
Pregnant/Nursing	❍Yes ❍No	
Prostate Disorder	❍Yes ❍No	❍_____

Other:_____

EAR, NOSE, THROAT	Self:	Family (list relation):
Dry Mouth	❍Yes ❍No	❍_____
Hearing Loss	❍Yes ❍No	❍_____
Sinusitis	❍Yes ❍No	❍_____

Other:_____

HEMATOLOGIC/LYMPHATIC	Self:	Family (list relation):
Anemia	❍Yes ❍No	❍_____
Breast Carcinoma	❍Yes ❍No	❍_____
Leukemia	❍Yes ❍No	❍_____

Other:_____

IMMUNOLOGIC	Self:	Family (list relation):
Herpes Simplex (cold sore)	❍Yes ❍No	❍_____
Sarcoidosis	❍Yes ❍No	❍_____
Sjogren's Syndrome	❍Yes ❍No	❍_____

Other: _____

INTEGUMENTARY	Self:	Family (list relation):
Rosacea	❍Yes ❍No	❍_____
Psoriasis	❍Yes ❍No	❍_____
Scleroderma	❍Yes ❍No	❍_____

Other: _____

MUSCOSKELETAL	Self:	Family (list relation):
Arthritis (Osteo)	❍Yes ❍No	❍_____
Arthritis (Rheumatoid)	❍Yes ❍No	❍_____
Myasthenia Gravis	❍Yes ❍No	❍_____

Other:_____

NEUROLOGICAL	Self:	Family (list relation):
Brain Tumor	❍Yes ❍No	❍_____
Headache (Migraine)	❍Yes ❍No	❍_____
Multiple Sclerosis	❍Yes ❍No	❍_____

Other:_____

PSYCHIATRIC	Self:	Family (list relation):
ADD	❍Yes ❍No	❍_____
Anxiety	❍Yes ❍No	❍_____
Depression	❍Yes ❍No	❍_____

Other:_____

RESPIRATORY	Self:	Family (list relation):
Asthma	❍Yes ❍No	❍_____
Emphysema	❍Yes ❍No	❍_____
Lung Cancer	❍Yes ❍No	❍_____

Other:_____

SOCIAL HISTORY

Do you smoke tobacco? ❍Yes: _____packs/week for _____years
❍No ❍Formerly (Quit ____ years ago)

Do you drink alcohol? ❍Yes: _____drinks/week for _____years
❍No ❍Formerly (Quit ____ years ago)

Do you use recreational drugs?
❍No ❍Yes: Type & frequency_____

Have you ever had a blood transfusion? ❍Yes ❍No

Do you have any sexually transmitted diseases? ❍Yes ❍No ❍HIV