Beloit Family
EYE CARE

Patient Name _____

DOB ____ /____ /____ SSN_____-_____-_____ (required if billing insurance)

Address _____ City_____ State___ Zip_____

Phone: Cell _____ Home _____

Email_____

Primary care physician_____ Clinic _____

Whom may we thank for referring you to our office? _____

How did you hear about our office? _____

What is your reason for today's visit? Check all that apply.

- ☐ Blurry vision distance
- ☐ Blurry vision reading
- ☐ Double vision
- ☐ Eye pain
- ☐ Computer strain
- ☐ Headaches
- ☐ Lazy eye
- ☐ Mucous discharge
- ☐ Loss of side vision
- ☐ Loss of central vision
- ☐ Broken Glasses
- ☐ Lasik
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Age-related Macular Degeneration
- ☐ Floaters/spots in vision
- ☐ Flashes
- ☐ Light sensitivity
- ☐ Itchy
- ☐ Gritty feeling
- ☐ Redness
- ☐ Watery/tearing
- ☐ Dryness
- ☐ Contacts
- ☐ Other _____

List any allergies _____

Are you taking any medications? If yes, please list _____

_____

_____

Patient Medical History (Check all that apply)

Constitution

- ☐ Developmental Disability
- ☐ Cancer
- ☐ Fatigue Syndrome

Ear, Nose, & Throat

- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Neurological

- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Autism Spectrum

Psychiatric

- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Dementia

Cardiovascular

- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Sleep Apnea

Gastrointestinal

- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ STD
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant/Nursing (currently)

Musculoskeletal

- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

Integumentary

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex Cold Sores
- ☐ Herpes Zoster/Shingles

Endocrine

- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hormonal dysfunction

Hematological/Lymphatic

- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ High Cholesterol
- ☐ Ulcer

Allergic/Immune

- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Eyes

- ☐ Glaucoma Suspect
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal Hole/Detachment
- ☐ Retinal Degeneration
- ☐ Keratoconus
- ☐ Injury
- ☐ Nystagmus

Family History (Immediate)

- ☐ Cancer _____
- ☐ Hypertension _____
- ☐ Type 2 Diabetes _____
- ☐ Type 1 Diabetes _____
- ☐ Hyperthyroidism _____
- ☐ Hypothyroidism _____
- ☐ Glaucoma _____
- ☐ Cataract _____
- ☐ Age-related Macular Degeneration _____