

ENOCHS EYE CARE, PLLC
3575 Bridge Road, Suite 21
Suffolk, VA 23435
Phone: 757-638-2015 Fax: 757-638-2010

PATIENT INFORMATION: (PLEASE PRINT OR CIRCLE THE APPROPRIATE INFORMATION BELOW)

Patient Full Name: _____
Patient Responsible Party: _____ Resp. Pty. SSN: _____ R.P. DOB: _____
Pt. Street Address: _____ Apt#: _____
City: _____ State: _____ Zip Code: _____ Country: _____
Patient DOB: _____ Patient Social Security#: _____ Gender: Male/Female
Marital Status: (Please Circle) Married/ Single/Widowed/Divorced/Other: _____
Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____
Employment Status: Full Time/ Part Time/ Retired/ Disabled/ Student/ Not Employed/Other _____
Patient Employer: _____
Occupation: _____
Emergency Contact Name: _____
Relationship to Patient: _____ Contact Phone#: (____) _____
Primary Care Doctor/Facility: _____ Office Phone #: (____) _____
Referring Doctor: _____ Office Phone#: (____) _____

INSURANCE INFORMATION: (PLEASE COMPLETE IN FULL)

1. Primary Insurance: _____ ID#: _____
Guarantor Name: _____ Home Phone: (____) _____
Guarantor SS#: _____ G. DOB: _____ Work Phone: (____) _____
Guarantor Place of Employment: _____
2. Secondary Insurance: _____ ID#: _____
Guarantor Name: _____ Home Phone: (____) _____
Guarantor SS#: _____ G. DOB: _____ Work Phone: (____) _____
Guarantor Place of Employment: _____

REASON FOR EXAMINATION: (PLEASE MARK ALL THAT APPLY)

____ Routine Eye Examination ____ Contact Lens Examination & Fitting ____ DMV/Work Exam
____ Eye Problems: (Mark all that apply and please explain below)
 ____ Blurry Vision ____ Excessive Tearing ____ Pain Eye ____ Itching
 ____ Decreased Vision ____ Seeing "Stars" ____ Irritation Red Eye ____ Halos
 ____ Trauma /Emergency ____ Floaters ____ Possible Infection
PLEASE EXPLAIN:

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO

If yes, please list the medication and describe any reactions you may experience:

LIST ANY MAJOR SURGERIES: (Please include the approximate date of occurrence)

MEDICATIONS: ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NO

(IF YES, PLEASE LIST WHAT KIND AND DOSAGE BELOW, PLEASE INCLUDE OVER THE COUNTER MEDS)

NAME OF MEDICATION	STRENGTH	DOSE	FREQUENCY

REVIEW OF SYSTEMS

Have you ever had any problems in the areas listed below? If so, please mark all areas that apply. If you have questions, please ask for assistance from an associate.

	NO	YES	?		NO	YES	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/ Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (SKIN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL				Runny Nose/ post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
EYES				Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Haze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR/CARDIOVASCULAR			
Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Starburst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Sandy/Gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY			
Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SKELETAL/JOINTS/MUSCLAR			
Infection of eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Connective Tissue Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
Diabetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED YES TO ANY OF THE ABOVE, OR IF YOU HAVE CONDITIONS NOT LISTED, PLEASE EXPLAIN:

PERSONAL/FAMILY MEDICAL HISTORY: [Please note any family history: parents, grandparents, siblings, children,(living or deceased)] HAVE YOU OR ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING CONDITIONS?

	NO	YES	SELF	WHEN	FAMILY	WHO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
RETINAL DETACHMENT/DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
MACULAR DEGENERATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
CROSSED EYES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
LAZY EYE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
BLINDNESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
DEATHS DUE TO ANESTHESIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

SOCIAL HISTORY

Do you use tobacco products? _____ (If YES, what type/ how much) _____
Do you use alcohol products? _____ (If YES, what type/ how much) _____
Do you use illegal drugs? _____ (If YES, what type, how much) _____
Have you been exposed to, or do you have, or ever have had: HEPATITIS B / HIV/ AIDS/ OTHER: _____

PREVIOUS PRESCRIPTION INFORMATION**CONTACT LENS INFORMATION**

Do You Wear Contact Lenses? YES/NO _____ Type of Lens: __ SOFT __ DAILY __ EX. WEAR __ RGP __ HARD
How long have you been wearing contact lenses? _____ How many hours a day? _____
Solutions used: _____ Rewetting Solutions: _____
CURRENT CONTACT LENS RX: _____ DATE PRESCRIBED: _____ by Dr. _____
Right eye: NAME _____ POWER _____ BC _____ DIAMETER _____
Left eye: NAME _____ POWER _____ BC _____ DIAMETER _____

PRESCRIPTION GLASSES INFORMATION

Do You Wear Prescription Glasses? YES / NO _____
Reason for Lenses: DISTANCE ONLY/ NEAR ONLY/ READING / DISTANCE & NEAR/ COMPUTER ONLY
If Lenses Used For Distance & Near, or Reading Vision, What Type Of Lens Is Being Used?
_____ Single Vision _____ Bifocal _____ Trifocal _____ Progressive (name of Prog. Ln. _____)
How long have you been wearing prescription glasses? _____
How many hours per day? _____ Do you have problems with glare? _____
Do you have problems with driving at night or night vision in general? _____
To your knowledge, have you previously used any type of anti-reflective coating on your lenses? _____

Computer Use:

Do you frequently use computers? YES / NO _____
How many years have you used computers? _____
How many days per week does your usage entail? _____
How many hours per day does your usage entail? _____
Do you often get headaches or feel "eye strain" after prolonged encounters viewing a screen? _____
Describe any additional information pertaining to your use of computers:

In the space provided below, please provide any additional information, concerns, questions, or issues that have not been addressed previously in this form.

Patient Signature: _____ Date: _____

1st Date Reviewed: _____ Initials: _____ Date Tech/Dr. Reviewed: _____ Initials: _____

2nd Date Reviewed: _____ Initials: _____ Date Tech/Dr. Reviewed: _____ Initials: _____