MACADAM VISION CLINIC

PATIENT HISTORY

Today's Date: _____

Name: _____

(Last, First, Middle Initial)

Nickname: _____

Gender: Male: _____ Female: _____

Mr: ___ Mrs: ___ Ms: ___ Miss: ___ Other: ___

Birthdate: _____/_____/_____

Last 4 Digits of SSN: _____

Occupation: _____

Employer: _____

COMMUNICATION HISTORY

Communication Info: Please Circle Preference:

Cell Home Work Email US Mail

❒ Home: ( ) _____ - _____

❒ Work: ( ) _____ - _____

❒ Cell: ( ) _____ - _____

Email: _____

Street: _____

City: _____

State: _____ Zip: _____

NEW PATIENT ONLY

Who may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

❒ Insurance List ❒ Our Website

❒ Signage ❒ Yelp

❒ Google Search ❒ Mailer

❒ Referred by Another Clinic

❒ Other _____

PATIENT HISTORY

Medical Insurance: _____

Subscriber Name: _____

Subscriber Birth Date: _____

Subscriber ID#: _____

Patient ID# if different: _____

Group # _____

Last 4 Digits of SSN: _____

Occupation: _____

Vision Insurance: (if different than above):

_____

_____

_____

Secondary Insurance: _____

_____

_____

RESPONSIBLE PARTY INFORMATION

Person responsible for account: ❒ Self

❒ Other: _____

(Last, First, Middle Initial)

_____

(Address)

_____

(City/State/Zip)

_____

(Phone Number)

❒Mother ❒ Father ❒Guardian

Do you participate in a flex spending account?

❒ Yes ❒ No

LIFESTYLE QUESTIONS

Do you..... **(check box if your answer is yes)**
Which digital device do you use?
❒Computer ❒Laptop ❒IPad ❒ Other_____
How many hrs/day each on each device? _____
Do you... (check box if your answer is yes)
❒...spend time outdoors? How much?___ Hrs/week
❒...have prescription eyewear?
❒...want information on Laser Vision Correction surgery?
❒...have interest in pharmaceutical grade supplements for eye health?
❒...have more than one pair of current Rx eyewear?
❒...have family members in need of eye care?
❒...have children?
❒...headaches... ❒Mild ❒ Moderate ❒Severe

What is the primary purpose of this visit?
_____

Any problems with your current contact lenses or glasses?
_____
Medical Allergies? Y / N What Happens?_____
_____

SOCIAL HISTORY

Alcohol Use: ❒Yes ❒No
If Yes: # of drinks per week _____
Tobacco Use: ❒ Yes ❒No ❒ Former Smoker
If Yes:
Smoked for _____ years
Packs per day _____
Hobbies_____
_____
Name of Family Doctor: _____
Date of last visit _____

FAMILY MEDICAL/EYE HISTORY

I have been diagnosed with: (check those that apply)	Do you have a family history of: (Please list the relationship of the family member to you
❒ Glaucoma	❒ _____
❒ Macular Degen	❒ _____
❒ Eye Injury	❒ _____
❒ Retinal Disease	❒ _____
❒ Other Diseases	❒ _____
❒ Blindness	❒ _____
❒ Strabismus	❒ _____
❒ Amblyopia	❒ _____
❒ Diabetes	❒ _____
❒ Dry Eye	❒ _____
❒ Other	❒ _____

_____

PATIENT MEDICAL HISTORY

Please list all the medications you are taking (include eye drops, birth control, supplements)
_____
_____
_____

Would you consider your overall health good? Y / N
Have you ever been diagnosed or treated with the following health problems?

	YES	NO
Cardiovascular	❒	❒
High Cholesterol	❒	❒
Hypertension	❒	❒
Ear, Nose, Mouth, Throat	❒	❒
Respiratory	❒	❒
Gastrointestinal	❒	❒
Genitourinary	❒	❒
Musculoskeletal	❒	❒
Psychiatric	❒	❒
Integumentary	❒	❒
Neurological	❒	❒
Endocrine	❒	❒
Hematologic/Lymphatic	❒	❒
Allergy/Immune	❒	❒

Other
Are you diabetic? ❒Yes ❒No
Type 1 **Type II** (non-insulin dependent)
Surgical History Procedures and Dates:_____
_____

PERSONAL EYE HEALTH HISTORY

	YES	NO
Do you feel you particularly sensitive to light?	❒	❒
Have you had any eye surgeries?	❒	❒
Have you had any eye injuries?	❒	❒
Do you have blurred vision?	❒	❒
Other eye problems? _____	❒	❒

Date of last eye exam: _____
Dr/Clinic _____
Do you currently wear contact lenses? ❒ Yes ❒ No
What Kind? _____
Solution used: _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

We are dedicated to improving our patient's quality of life by providing a clinical experience that evokes a sense of caring expertise memorable to the point of enthusiastic comment.