PRIMARY EYECARE CENTER
An Optometric Practice

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Name: Mr./Mrs./Ms./Dr. ________________________________
Preferred Name: ________________ **Sex: M F**
Address ____
City, State, Zip ____
Phone(H) ________________ **(C)** _______________________
Email ____
Primary Care Physician________________________________
Date & Reason for last PCP apt: _________________________
Last Eye Dr. & exam (if not here): ______________________
Reason for today's visit: _________________________________

Today's Date_________________
DOB: ______________________
SS#: _XXX-XX-______________
Marital Status: ______________
Occupation/Grade: ___________
Race: _______________________
Ethnicity: Hispanic/Latino
Non-Hispanic/Non-Latino

Referred By: _________________

Personal Medical History

Current Height _______ **Current Weight** ________

List all medications including oral contraceptives, aspirin, OTC medications, vitamins and herbal supplements (and dose if known):

____

____

Do you have any allergies to metals? **YES NO** (List allergy and reaction)

____

Do you have any allergies to medications? **YES NO** (List allergy and reaction)

____

List all major surgeries you have had with approximate date:

____

____

Are you pregnant/ nursing? **YES NO** (If yes, circle which one) If pregnant, list due date: _______________

Diabetics: Date of diagnosis (month/year) ____________ Last HbA1c (%) __________/ Date Taken ________
If self-monitored, list last measurement/ approximate date taken: ______________________________________

Do you wear glasses? **YES NO** How old are your glasses? ______________________
Do you wear contact lenses? **YES NO** How old is your current pair of lenses? ____________________
Do you work on the computer? **YES NO** Approximate hours per day: ____________________
****If yes,** How many monitors do you use? _______________
How many electronic devices do you use daily? __________________
(iPad, tablet, Kindle, desktop computer, laptop, cellphone, etc.)

Personal & Family Medical History

Please note any personal and family history (parents, grandparents, siblings, children: living or deceased) for the following:

List Self/Relatives Having the Condition

Glaucoma ______________________
Cataracts ______________________
Eye Injury ______________________
Blindness ______________________
Diabetes ______________________
Cancer ______________________

Macular Degeneration ______________________
Retinal Disease ___________________________
Amblyopia (lazy eye) ______________________
Strabismus (eye turn) ______________________
Other Major Disease _______________________
____

Social History

Do you use tobacco products? **YES** **NO** Type/ Amount/ How long? ________________________

If tobacco non-user: Former smoker/ Never smoker (circle one)

Do you drink alcohol? **YES** **NO** Type/ Amount/ How long? ___________________________

Do you use illegal drugs? **YES** **NO** Type/ Amount/ How long? _________________________

Eyes

- Blurred vision
- Distorted vision
- Halos
- Loss of vision
- Loss of peripheral
- Double vision
- Dryness
- Discharge
- Redness
- Sandy/gritty feeling
- Itching
- Burning
- Excess tearing/ watering
- Glare/ Light sensitivity
- Eye pain
- Flashing lights
- Floaters
- Chronic infections
- Tired eyes

Constitution

- Fever
- Weight loss/gain

Cardiovascular

- High blood pressure
- Cholesterol
- Angina
- Coronary artery disease
- Congestive heart failure
- Bypass graft

Ear, Nose, Mouth, Throat

- Sinus congestion
- Chronic sinusitis
- Runny nose
- Post nasal drip
- Chronic cough
- Dry throat/ mouth
- Hearing loss
- Ringing in ears/ Tinnitus
- Vertigo

Respiratory

- Asthma
- Chronic bronchitis
- COPD
- Emphysema
- Sarcoid
- Tuberculosis

Stomach/ Intestinal

- Diarrhea
- Constipation
- Gastric reflux
- Crohn's Disease
- Ulcerative Colitis
- Hepatitis

Genitourinary

- Genital/ Kidney/ Bladder

Muscles/ Bones/ Joints

- Arthritis
- Rheumatoid arthritis
- Osteoporosis

Psychiatric

- Depression
- Anxiety

Skin Conditions

- Eczema
- Psoriasis
- Dermatitis
- Skin cancer

Neurological

- Chronic headaches
- Migraines
- Seizures
- Multiple sclerosis
- Stroke
- TIA

Endocrine

- Diabetes Type 1
- Diabetes Type 2
- Prediabetes
- Thyroid disorder

Lymphatic/ Blood

- Anemia
- Systemic Lupus (SLE)
- Lyme Disease
- Other blood disorder

Allergies/ Immunologic

- Allergies/ Hay fever
- Autoimmune disorder
- HIV/AIDS

Cancer

- Type: ______________

If you answered YES to any of the above or have a condition not listed above, please explain:

____

____

____

Patient Signature: _______________________________ Date: _________________________________

I hereby certify that the above statements are true and correct to the best of my knowledge.