

**REGIONAL EYECARE ASSOCIATES**

*Drs. Mackey, Wickham & Read*

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Social Sec. # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Spouse's Name (or Parent, if child) \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone# \_\_\_\_\_

Date of Last Physical \_\_\_\_\_

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**FINANCIALLY RESPONSIBLE PARTY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_

Employer \_\_\_\_\_

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**VISION INSURANCE**

Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

**PRIMARY MEDICAL INSURANCE**

Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE**

Insurance Company \_\_\_\_\_ Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Employer \_\_\_\_\_

ID# \_\_\_\_\_ Group# \_\_\_\_\_

**INFORMATION VERIFIED:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**PATIENT HISTORY**

**VISUAL HISTORY:**

	Yes	No
Blurred Vision.....	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision.....	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision.....	<input type="checkbox"/>	<input type="checkbox"/>
Redness.....	<input type="checkbox"/>	<input type="checkbox"/>
Dryness.....	<input type="checkbox"/>	<input type="checkbox"/>
Itching.....	<input type="checkbox"/>	<input type="checkbox"/>
Burning.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain.....	<input type="checkbox"/>	<input type="checkbox"/>
Tearing or Discharge.....	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitivity or Glare.....	<input type="checkbox"/>	<input type="checkbox"/>
Flashes or Floaters.....	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision.....	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery or injury.....	<input type="checkbox"/>	<input type="checkbox"/>
Lazy or Crossed Eye.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration.....	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease or Detachment.....	<input type="checkbox"/>	<input type="checkbox"/>

**FAMILY HISTORY:**

DO ANY FAMILY MEMBERS HAVE THE FOLLOWING:

	Yes	No
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease/Detachment.....	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration.....	<input type="checkbox"/>	<input type="checkbox"/>
Lazy or Crossed Eye.....	<input type="checkbox"/>	<input type="checkbox"/>
Blindness.....	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

**SOCIAL HISTORY:** (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

If in school, what grade? \_\_\_\_\_

Are you pregnant or nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you drive?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco products?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use alcohol?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you use drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>

List any medications you currently take (prescription and over the counter) \_\_\_\_\_

List allergies to any medications: \_\_\_\_\_

List surgeries/hospitalizations you have had: \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please mark your health history below.

- CONSTITUTIONAL \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ headaches
  - \_\_\_ weight loss
  - \_\_\_ fever
  - \_\_\_ fatigue
- EAR, NOSE, MOUTH, THROAT none \_\_\_\_\_
  - \_\_\_ upper respiratory
  - \_\_\_ sinus
- CARDIOVASCULAR \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ heart disease
  - \_\_\_ hypertension
  - \_\_\_ stroke
  - \_\_\_ vascular disease
- RESPIRATORY \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ smoker
  - \_\_\_ bronchitis
  - \_\_\_ asthma
  - \_\_\_ emphysema

- GASTROINTESTINAL \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ crohn's
  - \_\_\_ colitis
  - \_\_\_ ulcer
- GENITOURINARY \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ urinary tract infections
  - \_\_\_ std
  - \_\_\_ kidney
- MUSCULOSKELETAL \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ fibromyalgia
  - \_\_\_ muscular dystrophy
  - \_\_\_ osteoarthritis
  - \_\_\_ ankylosing spondylitis
- INTEGUMENTARY (skin) \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ eczema
  - \_\_\_ rosacea
  - \_\_\_ psoriasis

- NEUROLOGICAL \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ multiple sclerosis
  - \_\_\_ epilepsy
- PSYCHIATRIC \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ depression
- ENDOCRINE \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ non-insulin dependent diabetes
  - \_\_\_ insulin dependent diabetes
  - \_\_\_ thyroid dysfunction
  - \_\_\_ hormone dysfunction
- HEMATOLOGICAL \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ anemia
  - \_\_\_ leukemia
- ALLERGIC/IMMUNE \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ rheumatoid arthritis
  - \_\_\_ HIV
  - \_\_\_ environmental allergies to what?/what happens?
- OTHER \_\_\_\_\_ none \_\_\_\_\_
  - \_\_\_ ADD
  - \_\_\_ ADHD
  - \_\_\_ AUTISM
  - \_\_\_ ASPERGER'S

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_