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EXCELLENT VISION

PATIENT HISTORY

[Please Print] DATE_____

MR / MRS / MS _____ DATE OF BIRTH_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

MAILING ADDRESS (If different) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

MOBILE PHONE (_____) _____ EMAIL_____@_____

SOCIAL SECURITY #_____

EMERGENCY CONTACT _____ PHONE (_____) _____

EMPLOYER_____ OCCUPATION_____

PRIMARY PHYSICIAN_____ PHONE (_____) _____

OPTOMETRIST _____ CITY: _____

REFERRED BY_____

PHARMACY _____ PHONE (_____) _____

Questions relating to the Patient Protection and Affordable Care Act (ACA) 2010:

PREFERRED LANGUAGE: _____

ETHNICITY: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Decline to answer ___ Unknown

RACE ___ American Indian ___ Alaska Native ___ Asian ___ Black or African American
___ Native Hawaiian ___ Other Pacific Islander ___ White ___ Decline to answer ___ Unknown

INSURANCE: 1. _____ 2. _____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

SPOUSE / NEXT OF KIN_____ PHONE_____

HOW DID YOU HEAR ABOUT US?

INDIVIDUAL: _____ DOCTOR: _____

RADIO: ___ WOKQ ___ WHEB ___ WQSX ___ WERZ ___ WBYY (THE BAY)
NEWSPAPER: ___ FOSTER`S ___ PORTSMOUTH HERALD ___ OTHER

PAST MEDICAL HISTORY

Please CHECK if you now have or have ever had any of the following:

When the incident occurred or when the condition was diagnosed

	YES	NO	
DIABETES	____	____	_____
HIGH BLOOD PRESSURE	____	____	_____
ASTHMA	____	____	_____
COPD / EMPHYSEMA	____	____	_____
HEART ATTACK	____	____	_____
ANGINA	____	____	_____
BLEEDING DISORDER	____	____	_____
G.I. DISEASE	____	____	_____
LIVER DISEASE / HEPATITIS	____	____	_____
KIDNEY DISEASE / STONES	____	____	_____
PERIPHERAL VASC DISEASE	____	____	_____
TUBERCULOSIS	____	____	_____
IRREGULAR HEART BEAT	____	____	_____
CARDIAC PACEMAKER	____	____	_____
STROKE	____	____	_____
ANEMIA	____	____	_____
HAYFEVER	____	____	_____
BRONCHITIS	____	____	_____
PNEUMONIA	____	____	_____
STOMACH ULCER	____	____	_____
ARTHRITIS	____	____	_____
CANCER OR TUMOR –LOCATION and TREATMENT	____	____	_____
THYROID DISEASE	____	____	_____
SEIZURES	____	____	_____
VARICOSE VEINS /LEG BLOOD CLOTS	____	____	_____
HIV, AIDS, Other Blood Disorders	____	____	_____

Family and Social History

Among your Blood Relatives, are there any of the following: Relative (s):

	YES	NO	
GLAUCOMA	____	____	_____
CATARACTS	____	____	_____
MACULAR DEGENERATION	____	____	_____
OTHER RETINAL DISEASES	____	____	_____
COLOR BLINDNESS	____	____	_____
UNEXPLAINED VISUAL LOSS	____	____	_____
BLINDNESS	____	____	_____

Past Ocular History (Past Eye History)

Have you had or been diagnosed with any of the following:

____ Eye Trauma – Type: _____ when: _____
____ Cataracts
____ Recurrent Corneal Erosion
____ Keratoconus
____ Allergic Conjunctivitis
____ Glaucoma
____ Corneal Ulcers
____ Iritis
____ Herpes Keratitis (Eye Condition)
____ Dry Eye Syndrome
____ Corneal Scars
____ Lazy or Crossed Eye(s)

Previous Eye Surgeries (please list the eye and approximately when the surgery occurred) PLEASE INDICATE IF NONE

1. _____
2. _____
3. _____
4. _____
5. _____

REVIEW OF SYMPTOMS: *DO YOU HAVE THE FOLLOWING?*

PLEASE CIRCLE THE APPROPRIATE SYMPTOM YOU ARE EXPERIENCING

Cardiovascular: chest pain, irregular heart beat, shortness of breath

Ear /Nose/ Throat Problems: dizziness, hearing loss, hoarseness, ringing in ears, sore throat

Neurological: balance problems, headache, numbness, tingling

Constitutional: fatigue, fever, night sweats, weakness, weight loss

Hematologic: bleeding, bruising, tender nodes

Psychiatric: anxiety, depression, insomnia, irritability, nervousness

Gastrointestinal: abdominal pain, constipation, heartburn, nausea, vomiting

Metabolic: cold intolerance, excess hunger, excessive thirst, frequent urination, heat intolerance

Respiratory: cough, trouble breathing, wheezing

Genitourinary: genital discharge, genital lesions, painful urination, urgency

Musculoskeletal: back pain, joint pain, muscle pain, stiffness, swelling

Skin: hair loss, rash, skin lesions

WHAT MEDICATIONS DO YOU TAKE REGULARLY? *PLEASE INDICATE IF NONE*

NAME	DOSAGE	TIMES DAILY
1		
2		
3		
4		
5		
6		
7		

ANY EYE DROPS OR EYE MEDS? *PLEASE INDICATE IF NONE*

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS SURGERIES: **YEAR:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

ALLERGIES:

_____ _____

_____ _____

SOCIAL HISTORY:

PLEASE CIRCLE THE APPROPRIATE ANSWER

SMOKING:

1. Current Everyday Smoker
2. Current Same Day Smoker
3. Former Smoker
4. Never Smoked

ALCOHOL:

1. Never
2. Rarely
3. Occasional
4. Daily
5. Frequent
6. Heavy

RECREATIONAL DRUGS:

1. Never
2. Rarely
3. Occasional
4. Daily
5. Frequent
6. Heavy

Type of Tobacco:
Cigar
Cigarettes
Pipe

Type of Alcohol:
Beer
Liquor
Wine

Type of Drug:
Amphetamine
Cocaine
IV drugs, LSD

OCCUPATION:
Business
Manual Labor
Office work
Retired
Student

HOBBIES:
Computer
Music
Sewing
Sports
Travel

I hereby authorize and direct the above-named insurance company to pay benefits directly to Northeast Corneal Consultants, PA (dba Excellent Vision Eye and Laser Centers). I further authorize this office, Excellent Vision Eye and Laser Centers, to release to the above-named insurance company any medical information necessary to obtain payment for my treatment. I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill.
I certify the above information is true and correct to the best of my knowledge and will notify Excellent Vision Eye and Laser Centers of any changes of the above stated information.
Should this account go delinquent, you may be responsible for all additional fees, collection fees, attorney fees, court costs, and administration fees.

PATIENT'S SIGNATURE: _____ Date: _____

Patient's Legal Guardian (if necessary): _____ Date: _____