JONESBOROUGH
EYE CLINIC

Name: _____ Sex: M / F Birth Date: _____

Street Address: _____ SSN: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Email: _____

Employer: _____ Occupation: _____

If your insurance is listed under someone else, please provide their name, birthdate, and SSN below.

Name: _____ Birth Date: _____ SSN: _____

Do you currently wear glasses? Y / N ☐ Full Time ☐ Part Time (☐ Distance ☐ Near)

Glasses owned: ☐ Single Vision (Distance / Reading) ☐ Progressives (No-line bifocals)

☐ Bifocals / Trifocals ☐ Computer ☐ Rx Sunglasses ☐ Non-Rx Sunglasses

☐ Sports Glasses for _____ ☐ Rx Safety Glasses

How old is your current pair of "everyday" glasses? _____

How many hours per day do you use a computer? _____

Do you experience any eye strain or fatigue with ☐ Computer use ☐ or reading?

Do you experience any visual difficulty driving during ☐ daytime ☐ nighttime ☐ rainy/poor weather?

Do you currently wear contact lenses? Y / N

Type / Brand of contact lenses: _____

If not wearing now, have you ever tried to wear contact lenses? Y / N Reason for stopping? _____

I am curious / interested in learning about advances in:
☐ Eyeglasses ☐ Contact Lenses ☐ Laser Vision Correction (LASIK)

Marital Status: ☐ Married (Spouse's Name: _____) ☐ Single ☐ Divorced

Use of alcohol: ☐ None ☐ Rarely ☐ Moderate If Moderate, please elaborate _____
Use of tobacco: ☐ Never ☐ Previously but not in past _____ years ☐ Yes _____ packs / day
Use of narcotics: ☐ None ☐ Recreational ☐ Chemical dependence

How did you first hear about us? (Circle One): Internet Insurance Driving/Walking by Patient Referral

Eye History: Are you currently taking any prescription or non-prescription drops / medication for your eyes? Y / N

If so, please list: _____

Have you ever had eye surgery? Y / N

Right eye: surgery for: _____ Year: ____ Left eye: surgery for: _____ Year: ____

Have you or do you now have any of the following conditions?

☐ Glaucoma ☐ Macular degeneration ☐ Cataracts ☐ Retinal tear / detachment / hole
☐ Foreign body sensation ☐ Eye Pain ☐ Double vision ☐ Blurred Vision ☐ Crusting
☐ Flashes of light ☐ Floating dark spots ☐ Itching ☐ Burning ☐ Redness ☐ Dryness
☐ Mucus discharge ☐ Light sensitivity ☐ Tearing ☐ Lazy eye / amblyopia ☐ Drooping eyelids

General Health History: Have you been treated or monitored for any of the following?

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Cholesterol ☐ Stroke ☐ Cancer
☐ Autoimmune

Primary Care Doctor: _____ Date of last physical: _____

Are you currently experiencing problems with any of the following? If yes, please explain.

☐ Ear/nose/throat (hearing loss, sinus problem, dry mouth, earache, laryngitis) _____
☐ Fever/fatigue, sudden weight gain or loss _____
☐ Neurological (numbness, headache, seizures, paralysis) _____
☐ Psychiatric (depression, ADD, anxiety, bipolar) _____
☐ Heart (chest pain, angina, irregular heart beat) _____
☐ Respiratory (cough, asthma, shortness of breath, COPD, sleep apnea) _____
☐ Gastrointestinal (abdominal pain, heartburn, ulcer, celiac disease) _____
☐ Urinary (pain when urinating, blood in urine, prostate hypertrophy, STD) _____
☐ Musculoskeletal (joint pain, stiffness or swelling, muscle pain or weakness) _____
☐ Skin problems (eczema, rosacea, psoriasis, rash) _____
☐ Endocrine (thyroid problems, hormone dysfunction) _____
☐ Hematologic / lymphatic (blood disorders, bruising, enlarged glands, anemia) _____
☐ Allergic / immunologic (reactions to foods, seasonal) _____
☐ Other physical condition _____

Family Health: Has anyone in your immediate family been diagnosed with any of the following? If so, which relation?

Blindness _____ Glaucoma _____
Retinal tear / detachment _____ Diabetes _____
Cataracts _____ Macular degeneration _____
Lazy eye (amblyopia) _____ Cancer _____

Medications: (prescription and over the counter) _____

_____

_____

Drug Allergies: Y / N _____

To the best of my knowledge, the questions on this form have If yes, list the medications been accurately answered. It is my responsibility to inform the doctor of any changes in my medical status. _____ Date _____