Patient Intake & History Form

Name: _____ Birth date: _____ Today's Date: _____

Address: _____ City/State/Zip: _____

Home phone: (____) _____ Cell phone: (____) _____

Email: _____

Employer/Occupation: _____

Insurance Information *(please check what applies)* : Eyemed____ Cigna____ MVP____ BCBS____
Martin's Point____ VSP____ Green Mountain Care____ Davis Vision____ Medicare____
Superior Vision____ Unitedhealth Care____ CBA Blue____

Please describe any specific concerns you would like to address with the doctor today:

_____

_____

Do you wear contact lenses currently? Y / N

If no: Are you <u>scheduled</u> to try contact lenses for the first time today? Y / N

Do/have you had any of the following?

Cataracts___
Double vision___
Headaches___
Head/eye injury___
Eye surgery___
Lazy eye___

Are you being watched and/or treated for any of the following? (*check all that apply*)

High blood pressure___
Diabetes___
Type:___
Insulin?___
Date of diagnosis:_____
Last A1C_____
Glaucoma___
Heart problems___
Respiratory problems___
Thyroid problems___
Cancer___

Please list any medications you are currently taking, or provide us with a list we can photocopy to keep in your chart.

_____

_____

Please check next to any of the following medications if you are taking them:

Plaquenil___ Corticosteroids___ Amiodarone___ Tamoxifen___ Ethambutol___

Are you currently pregnant or nursing? Y/N

Please check if you have a family history of any of the following:

Melanoma___
Diabetes____
Glaucoma___
Macular degeneration___
Cataracts___
Other eye diseases:_____