FLOWER MOUND EYECARE
Welcome to Our Office

Date ________________________

Last Name ________________________ First Name ________________________ MI _______
Address ____
City ________________________ State ____________ Zip ________________
Cell Phone ________________________ Home Phone ________________________
Date of Birth ________________ Occupation ________________ Email ________________
Emergency Contact Name ________________________ Phone Number ________________
Date of Last Eye Exam ________________ Referred By ________________________
Primary Vision Coverage ____
Policy Holder's Name____
Policy Holder's SS# ________________________ Policy Holder's DOB ________________

Medical Information

How is your general health? ____

Do you take any medications for any of these symptoms? (Please circle yes or no.)

Gastro intestinal	Y/N	Nervous	Y/N	Endocrine (glands)	Y/N
Ears/Nose/Throat	Y/N	Urinary	Y/N	Blood/Lymph	Y/N
Cardiovascular	Y/N	Muscles/Bones	Y/N	Allergic/Immunologic	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Headaches	Y/N
High Blood Pressure	Y/N	Eyes	Y/N	Mental	Y/N

Please explain ____
Diabetes Y/N ________________ Type ________________ Date of diagnosis________________
Allergies to medication Y/N Which? ________________ Reactions? ________________
Other health problems ____
Current medication(s) ____
Have you had any operations Y/N Kind? ________________ When? ________________
Name of family doctor and/or primary care physician ________________________
Date of last visit Date your blood pressure was last checked ________________________

Family History

High blood pressure	Y/N	Relation ____________	Macular degeneration	Y/N	Relation ____________
Diabetes	Y/N	Relation ____________	Retinal detachment	Y/N	Relation ____________
Glaucoma	Y/N	Relation ____________	Cataracts	Y/N	Relation ____________

Personal Eye Information

Do you have any eye conditions or problems? Y/N What kind? ________________________
Have you had any eye operations? Y/N Type ________________________
Have you had an eye injury? Y/N Kind ________________________

Do you have glaucoma?	Y/N	Cataracts?	Y/N	Dry Eye?	Y/N
Macular degeneration?	Y/N	Retinal Detachment?	Y/N	Blurred vision?	Y/N
Do you wear glasses?	Y/N	Contact lenses?	Y/N	Type ________________	

Additional Information ____

Yearly Update

Reviewed by ________________________ ○No changes Date ________________
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Reviewed by ________________________ ○No changes Date ________________