LOUISIANA EYE CARE

1330 S. Range Ave.
Denham Springs, LA 70726
225-664-2189

**WELCOME** Please complete **BOTH SIDES** of this form, **READ & SIGN** page 3 and return it to the front desk.

Date of Service: _____

Patient's Name: _____ Patient SSN: _____ DOB: _____ Age: _____
*(First)* *(Last)*

Address: _____ City: _____ State: _____ Zip: _____

Home / Cell Phone: _____ Text Messaging? Y / N Email: _____

Sex: M / F Marital Status: Single / Married / Other Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

## INSURANCE:

**VISION Insurance**

Name of Company: _____ ID#: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Address if Different From Patient: _____

**MEDCIAL Insurance**

Name of Company: _____ ID#: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Address if Different From Patient: _____

Is this a job related injury? Y / N If NO, continue to next section. If YES, please complete the following:

Date of injury/accident: _____ Did you report this to your EMPLOYER? Y / N

Employer: _____

Workman's Comp Contact Person: _____ Phone #: _____

Employer's Address: _____ City: _____ State: _____ ZIP: _____

Work Compensation Carrier: _____ Phone #: _____ Claim #: _____

OVER

## MEDICAL HISTORY

Last eye exam: _____ Do you wear glasses? Y / N Do you wear contact lenses? Y / N

Any eye surgeries? Y / N List:_____ Any eye injuries? Y / N List: _____

Have you ever been diagnosed with cataracts, glaucoma, macular degeneration, or any other conditions? Y / N List:

_____

Have any of your family members been diagnosed with glaucoma, macular degeneration, or any other conditions? Y / N List:

_____

## REVIEW OF SYSTEMS

Please CIRCLE all that apply or CHECK None

**Eyes** None _____
Distance vision blur
Near vision blur
Double vision
Distorted vision (halos)
Dryness
Itching
Burning
Sandy/Gritty
Mucous discharge
Excess tearing
Glare/light sensitivity
Eye pain
Flashes of light
Loss of vision
Floaters

**Respiratory** None _____
Asthma
Bronchitis
Emphysema
COPD
Sleep apnea

**Gastrointestinal** None _____
Crohn's disease
Colitis
Ulcer

**If Female:** pregnant or nursing? Y / N

**Genitourinary** None _____
UTI
Kidney disease
STD: viral, herpetic, chlamydia

**Musculoskeletal** None _____
Arthritis
Fibromyalgia
Osteoarthritis
Ankylosing spondylitis
Gout

**Integumentary** None _____
Eczema
Rosacea
Psoriasis
Herpes Simplex/Zoster

**Allergic/Immunologic** None _____
Drug allergy
Rheumatoid arthritis
Lupus
Sjogren's syndrome
HIV

**Neurological** None _____
Multiple sclerosis
Seizures
Migraines

**Other:** _____

**Psychiatric** None _____
Depression
Bipolar
ADD/ADHD
Anxiety

**Constitutional** None _____
Weight loss
Weight gain
Fever

**Endocrine** None _____
Diabetes Type I
Diabetes Type II
Thyroid dysfunction

**ENT** None _____
Upper respiratory infection
Sinus congestion
Hay fever

**Cardiovascular** None _____
Heart disease
High blood pressure
Stroke
High cholesterol

**Hematologic** None _____
Anemia
Leukemia

List **MEDICATIONS** you take (including oral contraceptions, asprin, and over-the-counter medications):

_____

_____

List **MEDICATION ALLERGIES:**

_____

## SOCIAL HISTORY

Do you smoke? Y / N Do you drink? Y / N Do you use illegal drugs? Y / N

Pharmacy _____