Benavente EyeCare

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Demographic Information

Today's Date: ___________________

Last Name:__________________________________ First Name: _______________________________ MI: ___________

Address: ____ City: _______________________ Sate: _____ Zip: __________

Phone Home: (______)__________________Mobile: (_______)__________________Work (_______)______________

Email: ______________________________________ Date of Birth:____________________ SSN:_____________________

Occupation:__________________________ Employer:_____________________ Medical Insurance:_________________

Vision Insurance: ____________________ How did you hear of us: current patient / internet / insurance / referral:___________

Emergency Contact Name/Phone Number:_______________________________________ _Relationship:_________________

Ocular History

Last Eye Exam:_______________ Eyeglasses: ____Y / N____ Contact Lens Wear: _____Y / N____

If yes: contact lens brand or type: _______________________________ contact lens solution: ____________________________

Have you ever been diagnosed with or treated for any of the following eye conditions:

	Self		Self	Family (indicate if siblings, parents or grandparents)
Eye Infection	Y / N	Glaucoma	Y / N	Y / N
Eye Injury	Y / N	Macular Degeneration	Y / N	Y / N
Eye Surgery	Y / N	Cataract	Y / N	Y / N
Flashes of Light / Floaters	Y / N	Retinal Detachment	Y / N	Y / N
Dry / Red / Gritty	Y / N	Amblyopia/Lazy Eye	Y / N	Y / N

Other eye condition(s) or symptom(s) not listed above:____

If yes to any questions above regarding YOURSELF, please explain diagnosis / treatment: ________________________________

____

Medical History

Name of Primary Medical Doctor: _________________________________ Last Medical Exam: ____________________________

Please list **MEDICATIONS** you take, both prescribed and Over-the-Counter: ____

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Please list any **Medication Allergies**: ____

Do **YOU** currently have a diagnosis **or** have ever been diagnosed with any of the following health conditions:

Diabetes (type I or II)	Y / N	Fever > 10 days or unexplained weight loss or gain	Y / N
Thyroid (hyper or hypo)	Y / N	Autoimmune disease (lupus, rheumatoid arthritis, etc)	Y / N
High Cholesterol	Y / N	Gastrointestinal (colitis, crohn's disease, etc)	Y / N
High Blood Pressure	Y / N	Genitourinary (kidney disease, bladder, etc)	Y / N
Heart Disease	Y / N	Skin (Acne, Eczema, etc)	Y / N
Stroke	Y / N	Ear / nose / throat conditions	Y / N
Seizures	Y / N	Allergy (environmental or food)	Y / N
Migraine / Headache	Y / N	Respiratory: asthma / bronchitis / emphysema / COPD	Y / N
Arthritis/Joint or Muscle pain	Y / N	Depression, anxiety, or other psych. disorder:	Y / N
Other:	Y / N	Surgery:	Y / N

Please Explain diagnosis date & treatment for conditions noted above: ____

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Family Medical History:		Social History:		If Yes, type / amount / frequency?
High blood pressure or heart disease	Y / N	Do you smoke or use tobacco products?	Y / N	
Diabetes	Y / N	Do you drink alcohol?	Y / N	
Stroke	Y / N	Do you use other substances?	Y / N	

My signature below acknowledges that I have answered the above questions regarding my health history to the best of my ability. I also acknowledge HIPPA privacy practices notice is available for review at my request.

___________________________________ ________________________________ __________ _______________

Signature of Patient or Legal Guardian | Name Legal Guardian (printed) if applicable | Date | Doctor Initials/Date