Welcome to Simply Eyes!

Thank you for choosing us for your eye care needs. We are delighted to have you as a patient, and appreciate the confidence you have placed in us. Please take a moment to fill out your information as accurately as possible. This information will be kept confidential.

Date			Sex ☐ Male ☐ Female	
Last Name	First Name		MI	Date of Birth MM / DD / YY
Salutation ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev.	Name Preference		E-mail Address	
Street Address	Apt#	City	State	Zip Code
Cell Phone Number	Work Phone Number		Home Phone Number	
Driver License Number	Social Security Number		Your Employer	
Person Responsible for Payment	Relationship to Patient		Your Occupation	

How Did You Hear About Us?

Family/Friend ☐ Insurance ☐ Google ☐ Yelp ☐ Facebook ☐ Walk-In ☐ Other: _____

Who May We Thank for Referring You?	Have We Seen Any Members of Your Family? If Yes, Who? ☐ Yes ☐ No
Name of Last Eye Doctor	Date of Last Eye Exam
Name of Primary Care Doctor	Date of Last Physical Exam

Name of Vision Insurance	Primary's Social Security Number		Policy Number	
Primary's Last Name	Primary's First Name	MI	Primary's Date of Birth	Marital Status ☐ Single ☐ Married ☐ Other
Name of Medical Insurance	Policy Number		Group Number	
Primary's Last Name	Primary's First Name	MI	Primary's Date of Birth	

Please Check Each Activity in Which You Participate			
☐ Aerobics	☐ Dance	☐ Music	☐ Volleyball
☐ Arts & Crafts	☐ Fishing	☐ Racquetball	☐ Water Skiing
☐ Baseball	☐ Football/Rugby	☐ Reading	☐ Weight Training
☐ Basketball	☐ Gardening	☐ Soccer	☐ Other:
☐ Boating	☐ Golf	☐ Sewing	☐ Other:
☐ Bowling	☐ Hunting	☐ Snow Skiing	☐ Other:
☐ Camping	☐ Martial Arts	☐ Swimming	☐ Other:
☐ Computers/Video Games	☐ Metal Working	☐ Television	☐ Other:
☐ Cycling	☐ Movies	☐ Tennis	☐ Other:

simplyeyes®

OCULAR HISTORY

NAME		**DATE**
DO YOU WEAR GLASSES?	YES ☐ NO ☐	Always ☐ Occasionally ☐ Work ☐ Reading Only ☐ Driving Only ☐
DO YOU WEAR CONTACT LENSES?	YES ☐ NO ☐	TYPE: ☐ Soft ☐ Gas Permeable — Brand of Contact Lenses:
CONTACT LENS REPLACEMENT SCHEDULE:		Daily ☐ 2 Weeks ☐ Monthly ☐ Quarterly ☐ Yearly ☐
HAVE YOU HAD LASIK / PRK? IF YES, WHEN?	YES ☐ NO ☐	Are you interested in LASIK or other refractive surgery? YES ☐ NO ☐
HAVE YOU EVER HAD ANY EYE INJURIES?	YES ☐ NO ☐	Please describe and indicate which eye:
HAVE YOU EVER HAD ANY EYE SURGERIES? IF YES, WHEN?	YES ☐ NO ☐	Please describe and indicate which eye:
HAVE YOU EVER BEEN DIAGNOSED WITH:	Cataract? YES ☐ NO ☐	Glaucoma? YES ☐ NO ☐ — Macular Degeneration? YES ☐ NO ☐ — Diabetic Retinopathy? YES ☐ NO ☐
PLEASE INDICATE ANY OF THE CONDITIONS THAT APPLY TO YOU:	☐ Blurred Far Vision ☐ Blurred Near Vision ☐ Poor Night Vision ☐ Double Vision	☐ Dry Eyes ☐ Watery Eyes ☐ Itchy Eyes ☐ Red Eyes — ☐ Floaters or Spots ☐ See Flashes ☐ Loss of Vision ☐ Light Sensitive — ☐ Headaches ☐ Eye Strain ☐ Eye Turn ☐ Eye Pain or Discomfort

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY EVER BEEN DIAGNOSED WITH THE FOLLOWING? IF A GRANDPARENT, INDICATE (M) MATERNAL OR (P) PATERNAL AND (GM) GRANDMOTHER OR (GF) GRANDFATHER.		
Blindness	☐ Yes ☐ No	Who?
Cataract	☐ Yes ☐ No	Who?
Glaucoma	☐ Yes ☐ No	Who?
Macular Degeneration	☐ Yes ☐ No	Who?
Retinal Detachment	☐ Yes ☐ No	Who?
Strabismus (Eye Turn)	☐ Yes ☐ No	Who?
Hypertension	☐ Yes ☐ No	Who?
Diabetes	☐ Yes ☐ No	Who?
Cancer	☐ Yes ☐ No	Who? Type?
Heart Disease	☐ Yes ☐ No	Who?
Thyroid Disease	☐ Yes ☐ No	Who?
Other:	☐ Yes ☐ No	Who?

PERSONAL MEDICAL HISTORY
REVIEW OF SYSTEMS

Please check if any of the following applies to you, and list any medication for each condition. If you have none of these conditions, then please check none.

Allergies (please list) ☐ **None** Medication Allergies: Environmental Allergies:	**Genitourinary:** ☐ **None** ☐ Kidney Stones ☐ Prostate Cancer ☐ STDs: ☐Uterine Cancer ☐Urinary Infections ☐ Other:	**Musculoskeletal:** ☐ **None** ☐ Ankylosing Spondylitis ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Scoliosis ☐ Other:
Cardiovascular: ☐ **None** ☐ Arrhythmia ☐ High Cholesterol ☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Other:	**Head/ENT:** ☐ **None** ☐ Dry Mouth ☐ Sinusitis ☐ Hearing Loss ☐ Ears Ringing ☐ Other:	**Neurological:** ☐ **None** ☐ Bell's Palsy ☐ Brain Tumor ☐ Migraines ☐ Multiple Sclerosis ☐ Myasthenia Gravis ☐ Other:
Constitutional: ☐ **None** ☐ Dizziness ☐ Fever ☐ Nausea ☐ Other:	**Hematological:** ☐ **None** ☐ Anemia ☐ Breast Cancer ☐ Leukemia ☐ Sickle Cell Disease ☐ Other:	**Psychiatric:** ☐ **None** ☐ Attention Disorder ☐ Anxiety Disorder ☐ Autism ☐ Bipolar Disorder ☐ Depression ☐ Other:
Endocrine: ☐ **None** ☐ Crohn's Disease ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Thyroid Disorder ☐ Other:	**Immunological:** ☐ **None** ☐ HIV ☐ Sarcoidosis ☐ Sjogren's Syndrome ☐ Lupus ☐ Other:	**Respiratory:** ☐ **None** ☐ Asthma ☐ Bronchitis ☐ COPD ☐ Emphysema ☐ Lung Cancer ☐ Other:
Gastrointestinal: ☐ **None** ☐ Colon Cancer ☐ Colitis ☐ Gallstones ☐ Hepatitis ☐ Gastroesophageal Reflux ☐ Other:	**Integumentary (Skin):** ☐ **None** ☐ Acne Rosacea ☐ Psoriasis ☐ Eczema ☐ Skin Cancer ☐ Other:	**Alcohol Use: Y N** **Tobacco Use: Y N** **Recreational Drug Use: Y N**

Please list all current medications including non-prescription and birth control.