Davison Road Optical **WELCOME** **Newfane Family Eyecare**

Last Name_____First Name_____Middle_____M F

Date of Birth____/____/____ SS#XXX-XX-_____ Today's Date_____/_____/_____

Address_____City_____State_____Zip_____

Home Phone_____ E-mail_____

Employer_____Work Phone_____ Occupation/Grade_____

Ethnicity/Language_____☐Spouse ☐Parent: Name_____

	Insurance Co.	Subscriber Name	Subscriber ID#	Subscriber DOB/Last 4 SS
Vision Ins.				
Health Ins.				

Primary Care Physician_____City_____Allergies_____
List any medications:_____
Primary reason for today's exam_____
Age of current glasses_____Date and location of last eye exam_____
Ever worn contacts lenses? Y N Type_____, do you have problems with vision and/or discomfort Y N?
Are you interested in contact lenses? Y N

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.
A social history and review of systems is part of a quality eye health evaluation, and many insurance companies require it.

Yes, I prefer to discuss my Social History information directly with my doctor (check box)☐.

Do you work at a computer? How many hours per day?	Y N	Do you want information on Laser Vision Correction surgery?	Y N
Do you have problem with light sensitivity?	Y N	Do you have interest in non-surgical Approach to vision correction?	Y N
Activities Hobbies Sports		Special Visual Demands?	Y N
Do you have trouble completing homework or assignments on time?	Y N	If you have children, how many?	Y N
Do you prefer not to wear your glasses at times?	Y N	Do you have a spare pair of glasses?	Y N
Do your eyes feel dry, gritty or burn?	Y N	Do you have prescription sunglasses?	Y N
Do you lose your place or do words move when reading?	Y N	Height Weight	
If you drive, do you have visual difficulty Driving?	Y N	If yes, describe	
Do you use tobacco products?	Y N	If yes, type/amount/how long	
Do you drink alcohol?	Y N	If yes, type/amount/how long	
Do you take illegal drugs?	Y N	If yes, type/amount/how long	

Have you ever been exposed to or infected with: ☐Gonorrhea ☐Hepatitis ☐HIV ☐Syphilis

Review of Systems

System	Diagnosis or Symptom	Yes	No	Family	If yes, please describe
Constitutional	Fever, weight gain or loss	☐	☐	☐	_____
Integumentary (skin)	Psoriasis	☐	☐	☐	_____
	Acne	☐	☐	☐	_____
	Rosacea	☐	☐	☐	_____
	Other	☐	☐	☐	_____
Eyes	Glaucoma	☐	☐	☐	_____
	Double Vision	☐	☐		_____
	Headaches or migraines	☐	☐	☐	_____
	Flashes/Floaters in vision	☐	☐		_____
	Cataracts	☐	☐	☐	_____
	Eye Injury or surgery	☐	☐		_____
	Macular Degeneration	☐	☐	☐	_____
	Retinal Problems	☐	☐	☐	_____
	Blindness/loss of vision	☐	☐	☐	_____
	“Lazy Eye”	☐	☐	☐	_____
	Blurred vision	☐	☐		_____
	Distorted vision/halos	☐	☐		_____
	Corneal problems	☐	☐	☐	_____
	Mucous Discharge	☐	☐		_____
	Redness/Itching	☐	☐		_____
	Excess watering	☐	☐		_____
	Tired eyes	☐	☐		_____
	Eye pain or soreness	☐	☐		_____
	Chronic Infection of eye	☐	☐		_____
	Sties or Chalazion	☐	☐		_____
Endocrine	Thyroid	☐	☐		_____
	Diabetes	☐	☐	☐	_____
	Other	☐	☐		_____
Ear, Nose, Mouth	Sinus Problems	☐	☐		_____
	Runny Nose	☐	☐		_____
	Post-Nasal drip	☐	☐		_____
	Chronic cough	☐	☐		_____
	Dry Mouth/Throat	☐	☐		_____
	Swollen Glands	☐	☐		_____
Respiratory	Asthma	☐	☐		_____
	Chronic Bronchitis	☐	☐		_____
	Emphysema	☐	☐		_____
Vascular	Heart/chest pain	☐	☐		_____
	High blood pressure	☐	☐		_____
	Carotid Artery Surgery	☐	☐		_____
	Heart Disease or surgery	☐	☐		_____
	Painful scalp	☐	☐		_____
	Stroke	☐	☐		_____
Gastrointestinal	Diarrhea	☐	☐		_____
	Constipation	☐	☐		_____
Genitourinary	Kidney or Bladder Problem	☐	☐		_____
Skeletal and Muscular	Arthritis	☐	☐		_____
	Muscle pain	☐	☐		_____
	Back or neck Problems	☐	☐		_____
	Joint or jaw pain	☐	☐		_____
Lymphatic/Hematologic	Anemia	☐	☐		_____
	Bleeding Problems	☐	☐		_____
Immunologic	Cancer	☐	☐		_____
	Immunosuppressed	☐	☐		_____
Psychiatric	Learning disabilities	☐	☐		_____
	AH(H)D	☐	☐		_____
	Depression/Anxiety	☐	☐		_____
	Other	☐	☐		_____

New Patients only: Whom may we thank for referring you to our office? Name:_____

( ) Another doctor ( ) Sign/building ( ) Yellow Pages ( ) Web Page ( ) Insurance list ( ) Newspaper/Radio