**EYE CLINIC OF WEST POINT**

**PATIENT INFORMATION SHEET**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_ SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone HM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Ins:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Ins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If this is a minor please include Parent or Guardian’s Name Below**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Ocular History:**

Circle yes or no

When, if ever was your last eye exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? Y/N

Do you presently wear or have you ever worn contact lenses? Y/N

**Have you ever had:** (Circle what applies to you)

Cataracts Dry Eyes Glaucoma Macular Degeneration Diabetic Retinopathy

Strabismus Detached Retina Flashing lights/ Floaters Cataract Surgery

Lazy eye Weak eye Crossed eyes Eye that turn in or out

Eye Surgery (when and where)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical History:**

Do you see a medical doctor, or have any problems with the following: (Circle what applies to you)

Heart conditions Respiratory Cancer GI Problems Musculoskeletal Allergy

Do you now have, or have you ever had:

Diabetes Headaches Thyroid Asthma Emphysema Cancer

Borderline Diabetes Stroke High Blood Pressure Heart Disease

What medicines are you taking

Ocular medications (eye drops):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

System medications (example: tylenol, blood pressure, high cholesterol meds, allergy):

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental Allergies ( Lidocaine ): Y/N

Have you had any operations?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social History: Smoking- None/0-1 pack per Day/ 1+ pack per day

 Alcohol- None/ Socially / 2-3 X per week/ with dinner

 Weight- Gain/ No change/ Loss

 Exercise- None/ Occasionally/ Weekly/ Daily

Has any immediate family had any of the below diseases: Circle all that apply

Glaucoma High Blood Pressure Cataracts

Retinal Detachment Macular Degeneration Heart Disease

Blindness Cancer Cataracts

Diabetes Stroke Crossed eyes

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE PROVIDED. WE ACCEPT CASH, CHECKS, CREDIT CARDS, MEDICARE, MEDICAID, VSP AND OTHER INSURANCES.**

Signed: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this document you agree to take responsibility for charges not covered by your insurance.**