EAST LANSING
FAMILY
EYECARE

PATIENT INFO AND HISTORY (page 1)

Exam date: _____/_____/_____

Name:____ DOB:_____/_____/_____ (age = ______)

Cell phone: (_____)________________________ Phone #2: (_____)________________________ hm / wk / other

LOCAL ADDRESS	PERMANENT ADDRESS (if different)
Street #:	Street #:
Apt:	Apt:
City,state,zip:	City,state,zip:

Referred to our office by:					
Approx date of last eye exam (if somewhere else):					
Appt scheduled by (circle):	phone	online	email	in-person	other
Currently wear (circle all that apply):	Glasses	Contacts	Rx sunglasses	Rx reading/computer glasses	

What is the MAIN REASON for your visit today?

	Primary **VISION** Plan	Primary **MEDICAL** Plan	Secondary **VISION** Plan	Secondary **MEDICA**L Plan
Plan Name:				
Contract or ID #:				
Name of member:				
Insured member DOB:				

**While we will attempt to assist you in working with your insurances, all co-pays, deductibles, and out-of-pocket expenses for materials and services are the responsibility of the patient. Initial eligibility and authorization information is not an insurance guarantee of payment.

EAST LANSING FAMILY EYECARE

PATIENT INFO AND HISTORY (page 2)

Name:____ DOB:_____/_____/_____ (age = ______)

Name of primary physician:	
Approx date of most recent physical:	
Name of your other medical doctors:	
Medications you take:	
Drug allergies and adverse reactions:	

Please check if other health systems are normal or abnormal	**Normal √**	**Abnormal √**		**Normal √**	**Abnormal √**
Constitutional: weight change, fever, fatigue			***Musculoskeletal:*** joint pain, stiffness, back pain		
Respiratory: cough, wheezing			***Skin:*** rash, sores, burning		
ENT: sore throat, sinus infection, hearing loss			***Allergic:*** hives, itch, eczema, hay-fever		
Cardiovascular: heart, blood-pressure, dizziness, swelling			***Neurologic:*** numbness, memory loss, tremors, frequent headaches		
Gastrointestinal: GI pain, diarrhea, constipation, blood in stool or urine			***Hematologic:*** bruise easily, gum bleed, enlarged glands		
Psychiatric: anxiety, depression, mood swings			***Endocrine***: hair loss, heat/cold intolerance		

Specific health conditions that commonly affect vision (check all that you have):

Diabetes □ (what was most recent A1C, if known?) ________ High BP □ Hyper/Hypo thyroid □

High cholesterol/lipids □ Rheumatoid arthritis □ SLE (Lupus) □ Multiple Sclerosis □ Cancer □

Migraines □ Traumatic Brain Injury □ Stroke □ Herpes infection (zoster or simplex) □

Eye Health History (check all that apply):

Glaucoma: □ self □ family ______________

Macular Degeneration: □self □ family______________

Cataracts: □ self □ family______________

Diabetic eye disease: □ self □ family______________

Crossed eyes: □ self □ family______________

Color blind: □ self □ family______________

Retinal detachment: □ self □ family______________

Fuchs cornea dystrophy:□ self □ family______________

Tobacco status: □ ex-smoker □ current smoker □ never

Drug or Alcohol abuse: □ history of abuse □ no abuse

Our office requires payment of patient obligation at time of service. We accept cash, credit card, American Express, and Care Credit payment plans. Contact lens related assessment, instruction, and after care is billed separately from your eye exam. Your information is protected by our privacy policy.