Welcome to LAKES Eye Clinic

First Name _____ MI ____ Last Name _____

Preferred Name _____ Email address _____

Address _____

City _____ State _____ Zip Code _____

Telephone # Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Female _____ Male _____Social Security #_____

Marital Status (circle one): Single / Married / Widowed / Divorced / Minor

Occupation _____ FT / PT

Employer / School _____ Grade/year in school _____

Emergency Contact Outside of Home _____ Relationship _____

Telephone # Home _____ Cell _____ Work _____

Spouse/Parent Name _____ DOB _____

Telephone # Home _____ Cell _____ Work _____

Primary Insurance Company _____ Secondary Insurance Yes / No

Subscriber Name _____ Relationship to Patient _____

Subscriber Address _____ DOB _____

ID # _____Group # _____

Date of last eye exam _____

Do you wear glasses? Yes / No ☐ All the time ☐Occasionally ☐Reading ☐Driving

Do you wear contact lenses? Yes / No If you wear contact lenses:
Type of wear: Daily / Extended wear Type of lens: Soft / RGP / Disposable
Brand of lens _____ Solution _____
Hours per day _____ Days per week _____ How often replaced _____

Have you ever had any eye surgery? Yes / No Type: _____ Date _____

Do you experience or have you been diagnosed with…

	YES	NO	PLEASE EXPLAIN
Change in Vision			
Glare or Light Sensitivity			
Eye Pain			
Eye Discharge			
Sandy or Gritty Feeling			
Itching / Burning Eyes			
Dry Eyes			
Red Eyes			
Floaters / Flashes			
Eye Strain / Tired Eyes			
Headaches			
Double Vision			
Crossed Eyes			
Glaucoma			
Cataracts			
Macular Degeneration			
Other			

SOCIAL HISTORY:

Do you take vitamins? Yes / No

Do you exercise regularly? Yes / No How often? _____

Do you drink alcohol? Yes / No If YES: occasionally 1/day 2-3/day 4+/day

Do you smoke? Yes / No If YES: occasionally ½ pk/day 1pk/day 1+/day

Do you use a computer? _____, If yes, how often: _____

Hobbies / Interest: _____

MEDICAL HISTORY:

Physician name _____ Date of last visit _____

Physician address _____

Do you have problems with	YES	NO	PLEASE EXPLAIN
Constitutional (weight loss/gain, fever)			
Ear, Nose, Throat (stuffy nose, ear aches, dry mouth)			
Cardiovascular (high blood pressure, heart disease)			
Respiratory (asthma, wheezing)			
Gastrointestinal (upset stomach, diarrhea)			
Genitourinary (genitals, kidney, bladder)			
Muscles, Bones, Joints (pain, arthritis)			
Skin (cancer, pimples, warts)			
Neurological (headaches, numbness, MS, seizures)			
Psychiatric (anxiety, depression)			
Endocrine (diabetes, hypothyroid)			
Blood / Lymph (high cholesterol)			
Allergic / Immunologic (sneezing, redness)			

Please list all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Please list any **medications** you currently take (prescription and over-the-counter): _____

_____

_____

Do you have any **allergies** to medications? **Yes / No** Please list: _____ Reaction: _____

Are you pregnant and/or nursing? **Yes / No**

FAMILY HISTORY:

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Glaucoma			
Macular Degeneration			
Retinal Detachment/Disease			
Blindness			
Crossed Eyes			
High Blood Pressure			
Heart Disease			
Diabetes			
Thyroid Disease			
Cancer			
Other			

Patient / Guardian / Legal Representative Signature :_____ Date: _____