Coastal Eye Care
Patient Information Form

(Please Print In Ink)

Do Not Write In This Space

Full Name (Mr./Mrs./Ms./Miss/Dr.) ____________________

Are you: ❑ Married ❑ Divorced ❑ Single ❑ Separated ❑ Widowed ❑ Minor (under 18 years old)

Parent's Name if Minor: ____________________

Address (and Mailing address if different) ____________________

City ____________________ State ________ ZIP ________

Home Phone ____________________ Work Phone ____________________

Date of Birth ____________ Age ________ Social Security Number _____ - ____- ______

Occupation ____________________Hobbies/Special Interest ____________________

Email Address (*Print Carefully*) ____________________

Whom may we thank for referring you to our office?

Purpose of your visit today ____________________

Date of Last Eye Exam ________ Eye Doctor's Name ____________Age of Present Glasses ________

Personal/Family Doctor's Name ____________________

Thank you for filling out this form. We are concerned with all aspects of your health and general welfare. Your careful attention in providing the following information is important. This information not only helps us care for you in an appropriate manner, it is also required by most insurance providers.

Personal and Family Health History

(please check / complete all that apply)

	Yourself	Your relatives? (what relation are they?)
High Blood Pressure	Yes ❑ No ❑	____________________
Diabetes	Yes ❑ No ❑	____________________
Glaucoma (high eye pressure)	Yes ❑ No ❑	____________________
Cataracts	Yes ❑ No ❑	____________________

Do you have frequent headaches? Yes ❑ No ❑ How long have they occurred? ____________

Have you had?				
Any eye injuries	Yes ❑ No ❑		Crossed eye(s)	Yes ❑ No ❑
Any eye surgeries	Yes ❑ No ❑		Lazy eye	Yes ❑ No ❑
Eye infections	Yes ❑ No ❑		Double vision	Yes ❑ No ❑

What are the dates and details of the occurrences regarding the above?

Current Medication History

Please list below all prescription and over the counter medications you are now taking and what they are for. Please include any diet or birth control medications.

Check here ❑ if you are not currently taking any medications.

Do you have any drug or other allergies? Yes ❑ No ❑ If Yes, please list:

Review of Systems

(Please check all that apply)

Do you have problems with: (Please check all that apply - give details in the space to the right)

Skin	Yes ❑ No ❑	______________
Ear, Nose, Throat and Mouth	Yes ❑ No ❑	______________
Lungs / Breathing (TB)	Yes ❑ No ❑	______________
Heart	Yes ❑ No ❑	______________
Thyroid Disorders	Yes ❑ No ❑	______________
Stomach / GI / Intestinal	Yes ❑ No ❑	______________
Genitals / Kidneys / Bladder	Yes ❑ No ❑	______________
Bones / Joints / Muscles	Yes ❑ No ❑	______________
Psychiatric / Mental Concerns	Yes ❑ No ❑	______________
Neurologic Systems	Yes ❑ No ❑	______________
Lymphatic System	Yes ❑ No ❑	______________
Blood or Bleeding Disorders	Yes ❑ No ❑	______________

Social History: Do you?				
Smoke	Yes ❑ No ❑		Drink Alcohol	Yes ❑ No ❑
Chew Tobacco	Yes ❑ No ❑		Use drugs	Yes ❑ No ❑

Please list any other significant health concerns or problems you have that are not listed above:

Payment is due on the date services are rendered unless prior arrangements have been made.

Please sign ______________________________ Date ______________