Welcome to Price Eye Care

Focusing on You Since 2002

Exam Date_____*Kindly turn phone off before your exam.

Patient's Legal First Name_____

M. Initial _____ Last Name_____

Suffix (Sr, Jr, II, III)_____Nick Name_____

Gender: Female Male Date of Birth_____

Race:
❒ American Indian or Alaska Native
❒ Asian
❒ African American
❒ Native Hawaiian or Pacific Islander
❒ White

Ethnicity:
❒ Non Hispanic or Latino
❒ Hispanic or Latino

Employment:
❒ Full-Time
❒ Part-Time
❒ Retired
❒ Unemployed

Student:
❒ Full-Time Student
❒ Part-Time Student

Your Mailing Address_____

City_____State_____ Zip_____

Home Ph_____Work Ph _____

Cell_____Email_____

Place of Employment (if applicable)_____

Your Vision Ins_____Your Medical Ins_____

Height_____Weight_____

PERSONAL HISTORY:
List all eye injuries, eye infections, or eye surgeries you have had:

_____

List all surgeries, major illnesses, or injuries, you have had:

_____

Your Family Dr._____Dr. Ph#_____

Last Eye Doctor _____Referring Doctor_____

Environmental Allergies_____

Allergies to Medications_____

_____

Current Medications with Dosages (or provide list if available)

_____

_____

_____

YOUR FAMILY MEDICAL HISTORY:

Please CHECK below all that apply to YOUR FAMILY HISTORY
***On the line please list who in the family has had this diagnosis:*
-Mother -Brother -Aunts -Son
-Father -Sister -Uncles -Daughter
-Maternal or Paternal Grandmother or Grandfather
-Maternal or Paternal Great-Grandmother or Great-Grandfather

CHECK HERE if your family history is UNKNOWN ❒

❒ Blindness _____
❒ Cataracts _____
❒ Macular Degeneration_____
❒ Glaucoma_____
❒ Retinal Detachment_____
❒ Crossed Eyes _____
❒ Lupus_____
❒ Cancer_____
❒ Diabetes_____
❒ Heart Disease _____
❒ High Blood Pressure_____
❒ Kidney Disease_____
❒ Arthritis _____
❒ Thyroid Disease_____

Your Occupation_____

Do you Drive? Y N If Yes, do you have difficulties driving? Y N

Do you Currently Smoke or use Smokeless Tobacco? Y N
If Yes, Type_____Amount_____Years_____

**ALL PATIENTS circle below - Please list your Smoking Status:
Smoke Everyday Smoke Somedays Former Smoker Never Smoked

Do you drink alcohol? Y N
If Yes, Type_____Amount_____Years_____

Do you use illegal drugs? Y N
If Yes, Type_____Amount_____Years_____

Please check if you have ever been exposed to:
❒ Gonorrhea ❒ Hepatitis ❒ Syphilis ❒ HIV

YOUR OCULAR HISTORY: Please CHECK all that apply to YOU:
❒ Vision Loss
❒ Blurry Vision
❒ Distorted Vision
❒ Double Vision
❒ Dryness
❒ Redness
❒ Mucous Discharge
❒ Gritty Feeling
❒ Itching
❒ Burning
❒ Excess Watering
❒ Light Sensitivity
❒ Eye Pain/Soreness
❒ Chronic Eye Infections
❒ Sties
❒ Flashes in your vision
❒ Floating Spots (Floaters)
❒ Tired Eyes
❒ Cataracts
❒ Diabetic Retinopathy
❒ Glaucoma
❒ Macular Degeneration
❒ Retinal Detachment
❒ Other _____

YOUR MEDICAL HISTORY: Please CHECK all that apply to YOU:

Gastrointestinal
❒ Colitis
❒ Crohns Disease
❒ Ulcers
❒ Constipation
❒ Diarrhea

Cardiovascular
❒ Heart Disease
❒ High Cholesterol
❒ High Blood Pressure

Constitutional
❒ Fever
❒ Weight Loss
❒Weight Gain
❒ Fatigue
❒ Trauma

Ear/Nose/Throat
❒ Allergies
❒ Sinus Congestion
❒ Runny Nose
❒ Post Nasal Drip
❒ Chronic Cough
❒ Dry Throat/Mouth

Skin
❒ Eczema
❒ Rosacea
❒ Psoriasis

Allergic/Immune
❒ Drug Allergies
❒ Seasonal Allergies
❒ Lupus
❒ Arthritis

Neurologic
❒ Headaches
❒ Migraines
❒ Seizures
❒ Multiple Sclerosis

Lymphatic
❒ Anemia
❒ Bleeding Problems
❒ Leukemia

Endocrine
❒ Type II Diabetes
❒ Type I Diabetes (Insulin Dependent)
❒ Thyroid Disease

Musculoskeletal
❒ Fibromyalgia
❒ Muscular Dystrophy
❒ Osteoarthritis
❒ Ankylosing Spondylitis

Respiratory
❒ Asthma
❒ Bronchitis
❒ Emphysema

Genitourinary
❒ Kidney Problems
❒ Bladder Problems
❒ STDs

Does Dr Price have permission to DILATE your eyes? Y N

We now offer a brand new 3D Wellness Screening to help in early detection of macular degeneration, glaucoma, diabetes, cancer, and many other eye diseases.
The total cost is $30; the information is priceless. Y N

Would you like more information about LASIK surgery? Y N

*FEMALES: Is there any chance you may be pregnant? Y N

*ALL PATIENTS: List any additional information for your doctor:

_____

_____

Please return these forms to the front desk. Thank you!

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