www.advancedfamilyicare.com James A. Tuel, O.D.

WELCOME TO OUR OFFICE

Today's Date ________

Last ________ First ________ MI ____

Street ________

City ________ State ____ Zip Code ________

Home Phone ________

Cell Phone ________

Patient's SSN ________

Employer (or School) ________

Occupation (or Grade) ________

Spouse (or Parent's Name) ________

Spouse (or Parent's Work) ________

Patients Date of Birth________ Age ____ Sex M F

Email Address ________

What is the major purpose of this visit?

____

Are you experiencing any problems with your contact lenses or glasses? ________

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative ________

If not referred, how did you choose our office for your needs?

- ❑ Another Dr.
- ❑ Insurance List
- ❑ Saw Sign/Building
- ❑ Newspaper/Radio/TV
- ❑ Yellow Pages: Which directory? ________
- ❑ Web Site Name ________
- ❑ Other ________

Insurance Information

Vision Insurance ________

Subscriber Name ________

Subscriber SSN ________

Subscriber Birth Date ________

Primary Medical Insurance ________

Subscriber Name ________

Subscriber SSN ________

Subscriber Birth Date ________

Do you participate in a flex spending account? ❑ Yes ❑ No

How will you settle your account today?

❑ Cash ❑ Check ❑ Credit Card

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

		Relationship
Blindness	❑	________
Cataracts	❑	________
Corneal Problems	❑	________
Glaucoma	❑	________
Lazy Eye	❑	________
Macular Degeneration	❑	________
Retinal Problems	❑	________
Diabetes	❑	________
Heart Disease	❑	________

The information in this confidential case history form is critical for the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ________

Town ________

Date of Last Physical Check-up ________

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) ________

____

____

Allergies to Medications: ❑ Yes ❑ No

____

Have you ever been diagnosed or treated for the following?

- ❑ Allergies
- ❑ Diabetes
- ❑ Thyroid
- ❑ Asthma
- ❑ Heart Disease
- ❑ Other
- ❑ Arthritis
- ❑ High Blood Pressure
- ❑ Cancer
- ❑ Kidney
- ❑ Cholesterol
- ❑ Nerves

____

____

Patient Eye History

Date of Last Eye Exam ________

By Whom? ________

Do you currently wear contact lenses? ❑ Yes ❑ No

What kind? ________

Solutions Used ________

Are you interested in trying contact lenses? ❑ Yes ❑ No

Have you ever had PRK or LASIK surgery? ❑ Yes ❑ No

If so, when? ________

Do you……. (Check box if your answer is yes)

- ❑ ..Work at a computer?
- ❑ ..Think you might benefit from thinner, lighter lenses?
- ❑ ..Have interest in a "Test Drive" of the latest contact lens designs
- ❑ ..Spend time outdoors? (How much?) _____hrs/week
- ❑ ..Have prescription sunglasses?
- ❑ ..Prefer not to wear your glasses at times?
- ❑ ..Want information on Laser Vision Correction surgery?
- ❑ ..Have interest in a non-surgical approach to vision correction?
- ❑ ..Have more than 1 pair of current Rx glasses?
- ❑ ..Have children?
- ❑ ..Have family members in need of eyecare?

If you wear bifocals, do the lines or head tilting bother you?

❑ Yes ❑ No

If you wear contact lenses, are you satisfied with the vision and comfort? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following?

- ❑ Cataracts
- ❑ Iritis/Uveitis
- ❑ Corneal Abrasion
- ❑ Lazy Eye
- ❑ Eye infection
- ❑ Macular Degeneration
- ❑ Eye injury
- ❑ Retinal Detachment
- ❑ Glaucoma
- ❑ Other eye disorders

Do you experience or have you ever experienced?

- ❑ Blurry vision
- ❑ Flash of light
- ❑ Sunlight Sensitivity
- ❑ Burning
- ❑ Floater/spots
- ❑ Dry Eyes
- ❑ Tearing
- ❑ Grittiness
- ❑ Trouble seeing at night
- ❑ Headaches
- ❑ Itchiness
- ❑ Double Vision

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor (check box)

Do you have difficulty with glare when driving at night? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

If yes, type/amount/how long: ______________________________

Do you drink alcohol? ☐ Yes ☐ No

If yes, type/amount/how long: ______________________________

Do you take illegal drugs? ☐ Yes ☐ No

If yes, type/amount/how long: ______________________________

Have you ever been exposed or infected with:

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	*NO*	*YES*	*?*
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Watering	☐	☐	☐
Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/Other Glands	☐	☐	☐

	NO	*YES*	*?*
EARS, NOSE, MOUTH			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Kidney/Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you have answered YES to any of the above or have a condition not listed, please explain and list medications:

____

____