EVOLVE EYECARE

Patient Information

Title: Mr. Mrs. Ms. Miss Please circle one

Name: _____
Birthdate: _____
SS#: _____
Address/Apt#: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Texting ok? yes/no Please circle one
Email: _____
Preferred Communication? Phone Email Cell Text

Single Married Divorced Widowed
Please circle one

If Minor, Parent or Guardian's name
_____

Employment Information

Patient's Employment Status: Please circle one
Full-time employed Student Retired

Part-time employed Not employed Self-employed

Occupation: _____
Employer: _____
Address: _____
City/State/Zip: _____
Phone: _____

Insurance Information

Medical Insurance: _____
Vision Insurance: _____

Policy Holder's Info (if not patient)
Name: _____
Home Address: _____
City/State/Zip: _____
Phone: _____
Employer: _____
Birthdate: _____
Relation to Patient: _____

How did you hear about our office?

Please circle one
I'm a Prior Patient Phone Book Newspaper
Insurance Internet Other Referral (see below)
Patient referral: _____
Doctor referral: _____

Emergency Information

Emergency Contact: _____
Relation to Patient: _____
Phone: _____

Primary Care Physician: _____
Address: _____
City/State/Zip: _____
Phone: _____

Authorization

I certify that I have read, understood, and provided the above information to the best of my knowledge. I understand that providing incorrect information to this office or the doctor may be dangerous to my health. I authorize the doctor and staff to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such eye care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or Evolve Eyecare, PLLC any insurance benefits intended for the payment of eye care services to me or my dependents.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependents. I understand that returned checks will be charged a $30.00 fee and that any account over 30 days past due will be subject to a $15.00 late fee as well as collection proceedings.

Missed appointments or appointments cancelled/re-scheduled with less than 24 hours notice will be charged a $25 cancellation fee.

I acknowledge that I have received a copy of Notice of Privacy Practices for Evolve Eyecare, PLLC.

X _____ Date: _____
SIGNATURE OF PATIENT (if patient is a minor, signature of guardian)

CONFIDENTIAL INFORMATION

EVOLVE EYECARE

NAME: _____ **DATE:** _____

Ocular History

Have you ever had any of the following eye conditions?

			Additional Information
Cataract/Cataract surgery	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Lazy Eye/Strabismus	Yes	No	_____
Eye Surgery	Yes	No	_____
LASIK/refractive surgery	Yes	No	_____
Eye Injury	Yes	No	_____

Do you wear contact lenses? Yes No
Type? □ Soft □ Disposable □ Hard/RGP □ Other
I wear my contacts _____ hours per day
Do you sleep in your contacts? No Yes
Which disinfecting system do you use? _____

How many hours do you use a computer each day? _____

Medical History

Allergies	Yes	No
Arthritis	Yes	No
Asthma/Emphysema	Yes	No
Other Lung Disease	Yes	No
Blood/Bleeding Disorder	Yes	No
Cancer (Type _____)	Yes	No
Diabetes (Type _____)	Yes	No

When were you first diagnosed? _____
What was your most recent blood sugar reading? _____
What was your most recent HbA1c reading? _____

Headaches	Yes	No
Heart Attack/Heart Failure	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
Kidney/Urinary Disease	Yes	No
Migraines	Yes	No
Peripheral Vascular Disease	Yes	No
Rosacea	Yes	No
Sarcoidosis	Yes	No
Sjogren's Syndrome	Yes	No
Skin Disease or Disorder	Yes	No
Sleep Apnea	Yes	No
Stomach/Intestinal Disorder	Yes	No
Stroke/Neurological Disease	Yes	No
Thyroid Disease	Yes	No

Medications

Please list all prescription and non-prescription medications you are currently taking

_____
_____
_____
_____
_____

Ocular Medications

_____
_____
_____

Please list all medication allergies:

_____
_____
_____

Surgical History

Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

Systemic Family History

Do any of your blood relatives have any of these conditions?

Diabetes	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Cancer	Yes	No

Other:_____

Ocular Family History

Glaucoma	Yes	No
Cataracts	Yes	No
Macular Degeneration	Yes	No
Lazy Eye/Strabismus	Yes	No

Other _____

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EVOLVE EYECARE

Review of Systems

Are you currently experiencing any of the symptoms listed below? □ **Yes** □ **No**

Eye Symptoms
□ Itching
□ Flashes and/or Floaters
□ Discharge/watering
□ Glare/Light sensitive
□ Pain
□ Eye fatigue
□ Lose place when reading
□ Focus difficulty

Cardiovascular
□ Chest pain or discomfort
□ Chest stiffness
□ Palpitations
□ Shortness of breath (dypsnea)

General Symptoms
□ Weight loss
□ Weight gain
□ Chills
□ Fatigue/weakness
□ Fever
□ Trouble sleeping

Endocrine
□ Heat intolerance
□ Cold intolerance
□ Sweating
□ Thirst
□ Poor blood sugar control

Gastrointestinal
□ Acid reflux
□ Appetite Loss
□ Heartburn
□ Nausea
□ Constipation
□ Diarrhea

Genitourinary
□ Frequency (polyuria)
□ Urgency

Ear, Nose, Mouth,Throat
□ Dry mouth
□ Hearing loss
□ Nosebleeds
□ Ringing in ears
□ Sinus disease/pain
□ Sore throat
□ Stuffiness

Head/Neck
□ Dizziness
□ Headache
□ Head injury
□ Pain
□ Stiffness

Hematologic/Lymphatic
□ Bruising, easily
□ Bleeding, easily
□ Leg cramps

Integument (Skin)
□ Rashes
□ Itching
□ Dryness
□ Hair and nail changes

Musculoskeletal
□ Back pain
□ Joint pain
□ Joint swelling
□ Muscle pain
□ Stiffness

Neurological
□ Fainting
□ Memory loss
□ Numbness
□ Seizures
□ Weakness
□ Tingling
□ Tremors

Psychiatric
□ Anxiety
□ Depression
□ Insomnia

Respiratory
□ Coughing
□ Shortness of breath
□ Wheezing

Social History

Do you smoke? □ Never smoked □ Former smoker □ Current every day smoker □ Smokeless tobacco
□ Current occasional smoker When did you stop smoking? _____ years ago

Alcohol usage? □ None □ 1-2 drinks daily □ Social □ Above average

Height _____ **Weight** _____ **Hobbies:** _____

Race American Indian/Alaska Native Asian Black/African American White

Ethnicity Hispanic or Latino Native Hawaiian or Other Pacific Island Not Hispanic or Latino

STAFF USE ONLY

_____ _____
Doctor has reviewed both pages of Health History Date

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