Coan Eye Care

WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING INFORMATION

Today's Date _____ /_____ /_____

PATIENT IDENTIFYING INFORMATION

LAST NAME ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR.	FIRST NAME	MIDDLE	DATE OF BIRTH / /	AGE
HOME ADDRESS	APARTMENT P.O. BOX	CITY	STATE	ZIP
DRIVERS LICENSE NUMBER	SOCIAL SECURITY NUMBER	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	GENDER ☐ MALE ☐ FEMALE	RACE
HOME TELEPHONE ( )	OFFICE TELEPHONE ( )	MOBILE TELEPHONE ( )	EMAIL ADDRESS	
EMPLOYER (SCHOOL)	OCCUPATION / (GRADE)	HOBBIES / LIFESTYLE		

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ INSURANCE ☐ PHONE BOOK ☐ NEWSPAPER AD ☐ LOCATION	REFERRED BY ☐ FRIEND ☐ PRIMARY CARE DOCTOR	WHO MAY WE THANK FOR REFERRING YOU?

IF PATIENT IS UNDER 18 YEARS OR STUDENT

NAME OF PARENT / GUARDIAN	HOME TELEPHONE	WORK TELEPHONE	MOBILE TELEPHONE

EMERGENCY CONTACT

EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE - PRIMARY	TELEPHONE - MOBILE

MEDICAL INFORMATION

NAME OF PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL EXAM	NAME (PLACE) OF PREVIOUS EYE DOCTOR	DATE OF LAST EYE EXAM

VISION INSURANCE COVERAGE

NAME OF INSURANCE COMPANY- VISION COVERAGE	GROUP NAME	GROUP NUMBER	INSURED IDENTIFICATION CARD
NAME OF POLICY HOLDER MEMBER	MEMBER DATE OF BIRTH	MEMBER SOCIAL SECURITY NUMBER	INSURANCE COMPANY TELEPHONE NUMBER
RELATIONSHIP TO PATIENT	MEMBER EMPLOYER	MEMBER WORK TELEPHONE	MOBILE TELEPHONE NUMBER

MEDICAL INSURANCE COMPANY

NAME OF MEDICAL INSURANCE COMPANY	POLICY HOLDER NAME (EMPLOYEE)	POLICY HOLDER SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
GROUP NAME	GROUP NUMBER	ID NUMBER	TELEPHONE NUMBER OF INSURANCE COMPANY

ABOUT YOUR EYE EXAMINATION

Several procedures are required to examine the health of the eye and determine treatment and/or the prescription for your eyewear. The comprehensive examination and/or any other procedure generally requires the instillation of eye drops to dilate the pupil of the eye. Dilating drops allow the doctor to examine the structures inside of the eye. These drops may result in light sensitivity, hazy vision and difficulty focusing at near, for a duration of four (4) to ten (10) hours. Please exercise caution while driving, operating equipment, or reading during the duration of these effects.

I acknowledge the importance of dilating drops, as well as, understand the effects on my vision and wish to **ACCEPT** / **DECLINE** the use of dilating eye drops.

_____ _____

Patient or legally authorized individual signature — Date

_____ _____

Printed name if signed on behalf of the patient — Relationship (parent, legal guardian, personal representative)

Reason for Visit

- ☐ Annual Examination
- ☐ Eye Health Examination
- ☐ Pre or Post Operative Care
- ☐ Emergency
- ☐ Other: _____
- ☐ Contact Lens Fitting
- ☐ Lasik Examination
- ☐ Diabetic Exam
- ☐ Glaucoma Evaluation

When was your last eye exam? _____

Do you currently:

	Yes	
Wear glasses?	☐	How long? _____
Wear contact lenses?	☐	Brand? _____
	☐	Years worn? _____
Work on a computer?	☐	# Hours per day? _____

Are you interested in:

Contact lenses?	☐	Type? _____
Changing your eye color?	☐	_____
Seeing without glasses?	☐	_____
LASIK eye surgery?	☐	_____

Have you had:

		Please Describe
Cataract Surgery?	☐	_____
Eye Muscle Surgery?	☐	_____
Retinal Surgery?	☐	_____
Refractive Surgery (LASIK)	☐	_____
Eye Injury? Trauma?	☐	_____

Do you experience?

- ☐ Blurred vision
- ☐ Burning
- ☐ Distorted vision
- ☐ Double vision
- ☐ Drooping eyelid
- ☐ Dryness
- ☐ Excess tearing / watering
- ☐ Eye pain or soreness
- ☐ Flashes of light
- ☐ Floaters
- ☐ Foreign body sensation
- ☐ Glare / light sensitivity
- ☐ Itching
- ☐ Loss of side vision
- ☐ Loss of vision
- ☐ Mucous discharge
- ☐ Night driving difficulty
- ☐ Redness
- ☐ Sandy or gritty feeling
- ☐ Tired eyes
- ☐ Uncomfortable glasses
- ☐ Other _____

Social History

Do you smoke? Yes No _____ packs per day

Do you drink alcohol? Yes No _____ drinks per day

Females

Are you pregnant or nursing? Yes No

Vision History

Do you or any blood relatives have any vision disorders?

F= Father **M**= Mother **S**= Sibling- sister/brother **GP**= Grandparent

	You	**Family Member**			
Amblyopia / Lazy Eye	☐	M	F	S	GP
Blindness	☐	M	F	S	GP
Cataracts	☐	M	F	S	GP
Color Blindness	☐	M	F	S	GP
Cross / Turned Eyes	☐	M	F	S	GP
Diabetic Retinopathy	☐	M	F	S	GP
Dry Eyes	☐	M	F	S	GP
Glaucoma	☐	M	F	S	GP
Keratoconus	☐	M	F	S	GP
Macular Degeneration	☐	M	F	S	GP
Other Vision Disorder	☐	M	F	S	GP

Health History

Do you have any health disorders?

☐ NO KNOWN HEALTH CONDITIONS

	Yes	No
Allergies (seasonal, environmental)	☐	☐
Arthritis	☐	☐
Blood / Lymph (Sickle cell anemia)	☐	☐
Bleeding tendency	☐	☐
Breathing problems	☐	☐
Cancer	☐	☐
Cardiovascular (heart, vessels, stroke)	☐	☐
Cholesterol	☐	☐
Collagen Vascular Disease, Lupus	☐	☐
Diabetes	☐	☐
Fever blisters / Cold sores	☐	☐
Gastrointestinal (stomach, bowel)	☐	☐
Genital, Kidney, Bladder	☐	☐
Headaches, Migraines	☐	☐
Hepatitis	☐	☐
Herpes simplex / Herpes Zoster / Shingles	☐	☐
High Blood Pressure	☐	☐
HIV Positive (AIDS)	☐	☐
Hormonal / Thyroid Disorder	☐	☐
Immunologic (Lupus, etc.)	☐	☐
Neurological (Multiple Sclerosis, etc.)	☐	☐
Nose, sinus, throat (infection, fever, cough)	☐	☐
Psychiatric (anxiety, depression, insomnia)	☐	☐
Respiratory (asthma, bronchitis, emphysema)	☐	☐
Skin conditions (acne, warts, skin cancer)	☐	☐

Other Disorders / Diseases

Please Describe

_____

_____

_____

Medication

List all medications and conditions treated (include nutritional supplements, recreational and over the counter drugs).

☐ None

_____

_____

_____

Condition being treated

☐ None

_____

_____

_____

Allergies

List all drug and food allergies (include medications, food, tape, latex and dyes).

☐ None ☐ Environmental ☐ Seasonal

_____

_____

_____