PATIENT FORM

ALEX Vision Source®
SIGNATURE EYE CARE™

GENERAL INFORMATION

First, Last, MI, Preferred Name Date

Street Address

City, State, Zip

Phone (Home) Phone (Cell) Phone (Work)

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Date of Birth Male/Female

Employer/School Occupation/School Grade *full-time* | *part-time*

Hobbies

Language, Race, Ethnicity

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Emergency Contact Person, Relationship, and Phone

I authorize: to share in my eye health care. Date: Signature:

PERSONAL HISTORY

Reason for today's visit

Date of last eye exam / / Clinic/Eye Doctor's Name

Date of last medical exam / / Primary Physician/Clinic

Height Weight Current Tobacco Use? (circle) Yes No Past Tobacco Use? (circle) Yes No

Alcohol Use? (circle one) None Rare Social 1 Drink Daily >1 Drink Daily

Are you currently pregnant or nursing? (circle) Yes No

How many hours a day do you spend on electronic screens (phone, computer, tablet, etc) Hours:

OCULAR HISTORY

Do you wear glasses? (circle) Yes No All the Time Occasionally Office Work Reading Only Driving Only

Do you wear contacts? (circle) Yes No Type: Replacement Schedule:

Eye injuries (circle) Yes No Type of injury/which eye?

Eye surgeries (circle) Yes No Type of surgery/which eye?

Eye medications (circle) Yes No Type of med/which eye?

Have you ever been diagnosed with?

Cataracts? (circle) Yes No Lazy Eye? (circle) Yes No

Glaucoma? (circle) Yes No Retinal Detachment? (circle) Yes No

Macular Degeneration? (circle) Yes No Other Eye Condition? (circle) Yes No Explain

Are you currently experiencing, or have experienced any of the following? (circle all that apply)

Blurred Vision - Distance	Eye Infections	Red Eyes	See Halos	Poor Color Vision
Blurred Vision - Near	Burning Eyes	Watery Eyes	Poor Night Vision	Light Sensitivity
Double Vision	Itchy Eyes	Floaters or Spots	Headaches	Migraine Headaches
Eye Strain	Dry Eyes	See Flashes	Loss of Vision	Crossed Eyes

...CONTINUED ON BACK >

PERSONAL MEDICAL HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE BEEN DIAGNOSED WITH (PAST AND PRESENT)

ENDOCRINE:
___ Type 2 Diabetes
___ Type 1 Diabetes
___ Thyroid Problem
___ Hormonal Dysfunction

CONSTITUTIONAL:
___ Trauma
___ Developmental Disability
___ Cancer
Type _____

EAR/NOSE/THROAT:
___ Hearing Loss
___ Upper Respiratory Infection

NEUROLOGICAL:
___ Multiple Sclerosis
___ Epilepsy
___ Cerebral Palsy
___ Tumor
___ Migraine
___ Neurofibromatosis

PSYCHIATRIC:
___ Depression
___ ADHD/ADD
___ Anxiety
___ Bipolar
___ Dementia
___ Other _____

CARDIOVASCULAR:
___ Hypertension
___ Stroke
Date: _____
___ Heart Disease
___ Vasular Disease
___ Congestive Heart Failure

RESPIRATORY:
___ Asthma
___ Bronchitis
___ Emphysema
___ COPD
___ Sleep Apnea

GASTROINTESTINAL:
___ Crohn's
___ Colitis
___ Ulcer
___ Acid Reflux
___ Celiac
___ Other _____

GENITOURINARY:
___ Kidney Disease
___ Prostate Disease
___ STD - (Herpetic/Chlamydia)
___ PCOS
___ Other _____

MUSCULOSKELETAL:
___ Osteoarthritis
___ Fibromyalgia
___ Muscular Dystrophy
___ Ankylosing Spondylitis
___ Osteoarthritis

DERMATOLOGIC:
___ Eczema
___ Rosacea
___ Psoriasis
___ Herpes Simplex/Cold Sores
___ Herpes Zoster/Shingles

HEMATOLOGICAL:
___ Anemia
___ Large Volume Blood Loss
___ High Cholesterol
___ Other _____

IMMUNOLOGIC:
___ Environmental Allergies
___ Rheumatoid Arthritis
___ Lupus
___ Sjogrens
___ AIDS/HIV
___ Other _____

CURRENT MEDICATIONS

PLEASE INCLUDE OVER THE COUNTER AND PRESCRIPTION MEDICATIONS, INCLUDING ORAL CONTRACEPTIVES

Medication Name	Dosage	Frequency	Condition

List any medication allergies: _____

List any other types of allergies: _____

FAMILY HISTORY

HAS ANYONE IN YOUR FAMILY (GRANDPARENTS, PARENTS, SIBLINGS, CHILDREN, LIVING OR DECEASED) EVER BEEN DIAGNOSED WITH:

Cataracts	Yes	No	Which Relative? _____	Type 1 Diabetes	Yes	No	Which Relative? _____
Crossed Eye	Yes	No	Which Relative? _____	Type 2 Diabetes	Yes	No	Which Relative? _____
Glaucoma	Yes	No	Which Relative? _____	Hypertension	Yes	No	Which Relative? _____
Lazy Eye	Yes	No	Which Relative? _____	Cancer	Yes	No	Which Relative? _____
Macular Degeneration	Yes	No	Which Relative? _____	Thyroid Disease	Yes	No	Which Relative? _____
Retinal Detachment	Yes	No	Which Relative? _____				

REFERRAL

HOW DID YOU HEAR ABOUT OUR OFFICE? (circle one) Family Friend Newspaper Internet Other _____

Name of the person who referred you to our clinic _____

Reviewed By: _____ Date: _____