METROWEST FAMILY EYE CARE

PATIENT'S NAME: _____ APPT DATE: _____

PATIENT'S PHONE: _____ EMAIL: _____

HOW DID YOU HEAR ABOUT US? GOOGLE PROVIDER SITE FRIEND FACEBOOK OTHER: _____

DOB: ____/____/____ OCCUPATION: _____ MALE OR FEMALE

LAST EYE EXAM: _____ NAME OF PREVIOUS EYE DOCTOR: _____

PRIMARY PHYSICIAN'S NAME: _____ PHONE: _____

PERSONAL MEDICAL INFO: CHECK BOX IF YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

- ☐ GASTROINTESTINAL
- ☐ EAR/NOSE/THROAT
- ☐ CARDIOVASCULAR
- ☐ RESPIRATORY
- ☐ HEADACHES
- ☐ NERVOUS SYSTEM
- ☐ GENITOURINARY
- ☐ MUSCULOSKELETAL
- ☐ SKIN
- ☐ MENTAL HEALTH
- ☐ ENDOCRINE GLANDS
- ☐ BLOOD/LYMPH
- ☐ ALLEGRIC/IMMUNOLOGIC
- ☐ SURGERIES (WHAT TYPE AND WHEN?)

ARE YOU IN GOOD HEALTH? YES OR NO

PLEASE LIST ANY ALLERGIES TO MEDICATION OR OTHER:

DO YOU SMOKE? YES OR NO HOW OFTEN: _____

DO YOU DRINK? YES OR NO HOW OFTEN: _____

DO YOU USE OTHER SUBSTANCES? YES OR NO WHAT AND HOW OFTEN: _____

DO YOU TAKE MEDICATIONS? YES OR NO PLEASE LIST NAMES AND HOW OFTEN:

CHECK BOX OF YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING AND EXPLAIN

- ☐ DIABETES
- ☐ GLAUCOMA
- ☐ HIGH BLOOD PRESSURE
- ☐ MACULAR DEGENERATION
- ☐ RETINAL DETACHMENT
- ☐ CATARACTS

CHECK BOX IF YOU HAVE ANY OF THE FOLLOWING:

- ☐ DRY EYES
- ☐ BLURRED VISION
- ☐ EYE SURGERIES
- ☐ EYE INJURIES
- ☐ WEAR GLASSES
- ☐ WEAR CONTACTS
- ☐ ANY EYE PROBLEMS? EXPLAIN
- ☐ INTERESTED IN LASER VISION CORRECTION?

PLEASE SIGN BELOW THAT YOU HAVE REVIEWED ALL OF INFORMATION ABOVE AND IT IS CORRECT TO THE BEST OF YOUR KNOWLEDGE.

SIGNATURE: _____ DATE: ____/____/____

PLEASE SIGN BELOW THAT YOU HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM *METROWEST FAMILY EYE CARE* AND THAT YOU UNDERSTAND YOUR RIGHTS

SIGNATURE: _____ DATE: ____/____/____