WELCOME TO SALEM HILLS FAMILY EYECARE

Thank you for choosing us!

Name (last)_____ (first)_____ (mi)_____ Date_____
Preferred Name_____ ❑Single ❑Married ❑Widowed ❑Divorced
Home Address _____ Date of Birth_____/_____/_____
City_____ ST_____ Zip _____ Preferred Phone (_____)_____
Email _____ Social Security Number_____
Preferred Language _____ Race_____

Whom may we thank for referring you? _____
Medical Insurance _____ Vision Insurance_____
Policyholder's Name_____ Policyholder's Date of Birth_____
Primary Care Doctor_____

Reason(s) for your visit today _____
_____

Glasses Do you wear glasses? ❑ Yes ❑No
Interested in getting new glasses? ❑ Yes ❑ No ❑ If my prescription changes

Contact Lenses Do you wear contacts? ❑ Yes ❑ No
Interested in trying contacts? ❑ Yes ❑ No

Eye Problems (Check all that apply)

- ❑ Cataracts
- ❑ Macular Degeneration
- ❑ Glaucoma
- ❑ Dry Eye
- ❑ Lazy Eye/ Eye Turn
- ❑ Retinal Detachment
- ❑ Diabetic Retinopathy
- ❑ Blurry Vision
- ❑ Poor Night Vision /Glare
- ❑ Itching / Allergies
- ❑ Watery Eyes / Discharge
- ❑ Light Sensitivity
- ❑ Pain
- ❑ Other_____
- ❑ Eyestrain
- ❑ Floaters
- ❑ Flashes
- ❑ Redness
- ❑ Double Vision
- ❑ Droopy eyelid

Occupation: _____ **Hobbies/Sports**: _____

Medications: ❑ None or List Here_____
_____

Allergies: ❑ None or List Here_____

Pregnant: ❑ Yes ❑ No **Nursing**: ❑ Yes ❑ No

MEDICAL HISTORY

Review of Systems - **Circle all that apply and fill in blank for others**

CONSTITUTIONAL: Developmental disabilities / Fatigue / Cancer, Type_____

EARS, NOSE, THROAT: Hearing loss / Sinusitis / Dry mouth / Laryngitis / _____

NEUROLOGICAL: Multiple sclerosis / Epilepsy / Cerebral Palsy / Tumor / Migraine / _____

PSYCHIATRIC: Depression / ADHD / Anxiety / Bipolar / _____

CARDIOVASCULAR: High blood pressure / Stroke / Heart disease _____

RESPIRATORY: Asthma / Bronchitis / Emphysema / COPD / Sleep Apnea / _____

GASTROINTESTINAL: Crohn's / Colitis / Ulcer / Acid reflux / Celiac disease / _____

GENITOURINARY: Kidney disease / Prostate disease / Herpes / Chlamydia / _____

MUSCULOSKELETAL: Arthritis / Fibromyalgia / Ankylosing Spondylitis /Gout / _____

INTEGUMENTARY: Eczema / Rosacea / Psoriasis / Cold Sores / Shingles / _____

ENDOCRINE: Type 2 Diabetes / Type 1 Diabetes / Hypothyroid / Hyperthyroid_____

HEMOTOLOGIC: Anemia / Blood Loss / Ulcer / High Cholesterol / _____

IMMUNOLOGIC: Rheumatoid Arthritis / Lupus / Sjogren's / HIV / Hepatitis / Syphilis / _____

List all major surgeries, injuries, hospitalizations: _____

Family History **List family member(s) that have the following**

Macular Degeneration	**Autoimmune Disease**
Glaucoma	**Diabetes**
Lazy Eye / Eye Turn	**Heart Disease**
Retinal Detachment	**Thyroid Disease**

Social History

Do you drink alcohol? ❑ No ❑ Yes, Amount: _____

Do you use tobacco products? ❑ No, never ❑ No, former user ❑ Yes, daily ❑ Yes, occasional

Do you use recreational drugs? ❑ No ❑ Yes, Type: _____