



PRIMARY EYE CARE

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Patient Demographic Information Form

Patient Information

Name: _____ Today's Date: ____/____/____

Preferred Name: _____

Birth Date: ____/____/____ ☐ Male ☐ Female

Age: _____ Height: _____ Weight: _____ Social Security: ____-____-____

Employer/School: _____ Last Eye Exam: ____/____/____

Marital Status: ☐ Married (Spouse Name) _____

☐ Single ☐ Widowed ☐ Divorced

Contact Information

Billing Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Preferred Phone: (____) _____ Alt. Phone: (____) _____

Email for Patient Portal: _____

Insurance Information

Vision Insurance: _____

Insurance ID # _____

Policy Group # _____

Policy Holder Name: _____

Medical Insurance: _____

Insurance Policy # _____

Policy Group # _____

Policy Holder Name: _____

• **Review of Systems-** Check all that currently apply

☐ Blurred Vision	☐ Poor Night Vision	☐ Total Loss of Vision
☐ Burning	☐ Glare from Headlights	☐ Eyestrain
☐ Double Vision	☐ Itching	
☐ Dryness	☐ Redness	
☐ Eye Pain/Soreness	☐ Watery Eyes	
☐ Floaters	☐ Sandy/Gritty Feeling	
☐ Flashes of Light	☐ Sensitivity to Light	
☐ Matted Eyes/Discharge	☐ Infection of Eye/Eyelid	

Medical History Questionnaire

Please list **all** current medications: _____

Pharmacy: _____ City: _____ State: _____

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

List **all** major surgeries or injuries you have had: _____

Have you ever been diagnosed with any eye problem or eye diseases? ☐ Yes ☐ No

If yes, please list: _____

Do you smoke? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

If yes, please list contact lens brand: _____

• **Family History-** Abbreviate **all** that apply:

M=Mother / **F**=Father / **S**=Sister / **B**=Brother / **A**=Aunt / **U**=Uncle / **GM**=Grandmother / **GF**=Grandfather

☐ Blindness	☐ Diabetes: Type (1) or (2)	☐ Heart Disease
☐ Cataract	☐ Cancer	
☐ Glaucoma	☐ Thyroid Disease	
☐ Macular Degeneration	☐ Arthritis	
☐ Retinal Detachment	☐ High Blood Pressure	

• **Current & Previous Medical Diagnoses-** Check **all** that apply:

Integumentary:

- ☐ Eczema
☐ Shingles

Neurological:

- ☐ Migraines
☐ Seizures

Endocrine:

- ☐ Thyroid Dysfunction

ENT:

- ☐ Environmental Allergies
☐ Sinus Congestion
☐ Runny Nose
☐ Post-Nasal Drip
☐ Chronic Cough
☐ Ear/Nose/Throat Problems

Respiratory:

- ☐ Asthma
☐ Chronic Bronchitis
☐ COPD

Vascular/Cardiovascular:

- ☐ Diabetes: Type (1) or (2)
☐ Heart Disease
☐ High Blood Pressure

Gastrointestinal:

- ☐ Stomach Issues

Bones/Joints/Muscles:

- ☐ Arthritis / Rheumatoid
☐ Muscle Pain
☐ Joint Disease

Other:

- ☐ Eye Disease
☐ Cancer
☐ Multiple Sclerosis
☐ Lupus
☐ HIV
☐ Hepatitis
☐ Psychiatric

Lymphatic/Hematologic:

- ☐ Anemia

Neurodevelopmental Disorder:

- ☐ Autism
☐ ADHD
☐ Nonverbal Learning Disorder