Frontier Eye Care
and Eyewear Gallery

Welcome

Welcome to our practice. If you have any questions or need assistance with this form, please let us know.

Patient Name: _____ Today's Date: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Birth Date: _____ Age: _____ Social Security #: _____ Sex: ☐ Male ☐ Female
Guardian (If Applicable): _____ Occupation: _____
Spouse's Name: _____ Employer: _____
Name of Medical Doctor: _____ Last Medical Exam: _____
Emergency Contact Name and Phone: _____ E-mail: _____

Payment is required at the time services are rendered. How will you be paying today?

☐ Cash ☐ Check ☐ Visa/MC/Discover ☐ Medicaid (T-19)* ☐ KidCare CHIP* ☐ Other Insurance* _____
*Please complete "Insurance Information" sheet and present insurance card(s) now. We do not accept assignment from all insurance plans.

Medical History Questionnaire

MEDICAL HISTORY

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____
_____
List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):
_____
_____
_____
List all major injuries, surgeries and/or hospitalizations you have had: _____
_____
_____
List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____
Are you pregnant and/or nursing? ☐ no ☐ yes
Do you wear glasses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ☐ no ☐ yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Brand: Are they comfortable? ☐ yes ☐ no

FAMILY HISTORY

Please note any family history for the following conditions: (parents, grandparents, siblings, children; living or deceased)

DISEASE/ CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/ Disease	☐	☐	☐	_____
Arthritis/ Lupus	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes

If yes, please describe: _____

Do you use tobacco products? ☐ no ☐ yes If yes, type/ amount/ how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type/ amount/ how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type/ amount/ how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ No

Review of Systems

Do you currently, or have you had any *recurrent* problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTINAL			
Fever, Weight Loss/ Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision or Side Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/ Halos	☐	☐	☐
Flashes in Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/ Watering	☐	☐	☐
Glare/ Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye/Lid	☐	☐	☐
Sties or Chalazion (Lid Bump)	☐	☐	☐
Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid/ Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/ Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/ CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/ Kidney/ Bladder	☐	☐	☐
BONES/ JOINTS/ MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/ HEMATOLOGIC			
Anemia	☐	☐	☐
ALLERGIC/ IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

X _____ _____ _____ _____

Signature (Patient or Guardian) Date Medical History Reviewed (Doctor Signature) Date

Acknowledgement of Receipt of Privacy Practices

It is our policy to present you with a copy of our Notice of Privacy Practices. The Notice is displayed in our reception desk, and is also available online at our website (frontier-eyecare.com). I acknowledge that I have received a copy of Frontier Eye Care's Notice of Privacy Practices.

X _____ _____

Signature (Patient or Guardian) Date