Welcome

Welcome to Herkert Family Eye Care. Please take a few minutes to fill out this form as completely as possible. If you have any questions, we will be glad to help.

PATIENT INFORMATION

Date: ______________

Patient's Full Name: ____________________

Address: ____________________

City: ______________State:____ Zip:_______

Sex: M F Birth Date: ________SSN: __________

Primary Language: ___English or __________

Single ☐ Married ☐ Widowed ☐ Divorced ☐

Race: White African American Asian American Indian Alaska Native Native Hawaiian Unknown Declined

Ethnicity: Declined Hispanic Latino Other

Email: ____________________

Home Phone: __________ Cell: ________

Spouse/Sig Other Name: __________

Birth Date: ________ SSN: __________

Whom may we thank for referring you? ________

ACCOUNT RESPONSIBLE

Name: ____________________

Address: ____________________

City St Zip: ____________________

Phone: ____________ Relation: ________

VISION/MEDICAL INSURANCE

Vision Insurance Name: __________

Member ID: ____________________

Birth Date of Subscriber: __________

Medical Insurance Name: __________

Member ID: ____________________

Group # ____________________

PRIMARY CARE INFORMATION

Physician's Name: __________

Address: ____________________

Phone: ____________________

Date of Last Visit: __________

EYE HEALTH HISTORY

Please mark Y for Yes or N for No to indicate if you or blood relatives have experienced any of the problems below:

	Yourself	Family Members	Relation
Glaucoma	Y N	Y N	________
Cataracts	Y N	Y N	________
ARMD (Age-Related Macular Degeneration)	Y N	Y N	________
Eye Injury	Y N	Y N	________
Retinal Disease	Y N	Y N	________
Blindness	Y N	Y N	________
Strabismus (Crossed Eyes)	Y N	Y N	________
Amblyopia (Lazy Eye)	Y N	Y N	________
Diabetes	Y N	Y N	________
Sjogren's Syndrome	Y N	Y N	________

	Yourself
Blurred Vision	Y N
Dry Eyes	Y N
Floaters/Spots	Y N
Headaches	Y N
Light Sensitive	Y N
Seeing Halos	Y N
Seeing Flashes	Y N
Watering Eyes	Y N
Bloodshot Eyes	Y N
Burning Eyes	Y N
Discharge from Eyes	Y N
Red Eyes	Y N
Itching Eyes	Y N
Eye Infection	Y N
Color Blind	Y N

Other Eye Problems

____

____

____

____

Previous Optometrist____________________

Date of Last Exam____________________

Do you wear glasses? Yes _____ No_____

Reading _____TV_____ Driving______

Do you wear Contact Lenses? Yes_____ No______

Type______________ Hours/Day__________

Contact Lens Solution__________________

Describe any problems you have had with your contacts:____________________

Please complete reverse side of form-thank you!

GENERAL HEALTH HISTORY

Please mark Y for Yes or N for No to indicate if you or blood relatives have experienced any of the following:

	Yourself	Family Members	Relation
Heart Disease	Y N	Y N	________
High Blood Pressure	Y N	Y N	________
Stroke	Y N	Y N	________
Emphysema	Y N	Y N	________
Asthma	Y N	Y N	________
Tuberculosis (TB)	Y N	Y N	________
COPD	Y N	Y N	________
Crohn's Disease	Y N	Y N	________
Irritable Bowel (IBS)	Y N	Y N	________
Kidney Disease	Y N	Y N	________
Muscular Dystrophy	Y N	Y N	________
Multiple Sclerosis	Y N	Y N	________
Arthritis	Y N	Y N	________
Rheumatoid Arthritis	Y N	Y N	________
Fibromyalgia	Y N	Y N	________
Eczema	Y N	Y N	________
Dermatitis	Y N	Y N	________
Shingles	Y N	Y N	________
Bell's Palsy	Y N	Y N	________
Epilepsy	Y N	Y N	________
Seizures	Y N	Y N	________
Migraines	Y N	Y N	________
Cancer	Y N	Y N	________
Chemical Dependency	Y N	Y N	________
HIV/Aids	Y N	Y N	________
Anemia	Y N	Y N	________
Depression	Y N	Y N	________
Dementia	Y N	Y N	________
Alzheimer's	Y N	Y N	________
Thyroid Condition	Y N	Y N	________

Other____

Social History

Alcohol Use Y N

Tobacco Use Y N

Drug Use Y N

Computer Use Y N

Hours per Day _____

Hobbies

____

____

Occupation

____

Are you pregnant? Y N

Due Date__________

MEDICATIONS

List all of the medications you are currently taking, including eye drops:

Name	Dose	How Often

ALLERGIES

List your allergies to medications & other substances:

Allergy	Reaction