Chart#: ______ Date of Visit:___/___/___ Name: ________________________________
For Office Use only Date of Birth:___/___/___Age:______ Gender: M F

....

Patient Contact Information: Please fill out **ALL** of the questions below:

Mailing Address: ________________________________ Last Physical Exam __________________________
City, State Zip: __________________________________ Last Eye Exam _____________________________
Primary Phone: __________________________________Hobbies ___________________________________
Nickname: ______________________________________Computer Use? Y N If yes, hours/day ________
Occupation: _____________________________________

Patient Medical History: Please **check** off your medical conditions: **If necessary please explain:**

Cardiovascular: ☐**high blood pressure**☐ **heart disease** ______________________________

Ear, Nose, Mouth, Throat: ☐**hearing loss** ☐**chronic cold** ☐**vertigo** ______________________________

Respiratory: ☐**asthma** ☐**COPD** ☐**sleep apnea** ☐**TB** ☐**sarcoid** ______________________________

Gastrointestinal: ☐ **Crohns** ☐ **hepatitis** ______________________________

Genitourinary: ☐**kidney disease** ☐**STD's** ______________________________

Musculoskeletal: ☐**arthritis** ☐**MS** ☐**gout** ______________________________

Dermatologic: ☐**skin cancer** ☐**eczema** ☐**rosacea** ☐**shingles** ______________________________

Neurologic: ☐**Bell's Palsy** ☐**migraines** ☐**seizures** ☐**stroke** ______________________________

Psychiatric: ☐**depression** ☐**dementia** ☐**bipolar** ☐**anxiety** ______________________________

Endocrine: ☐**diabetes** ☐**hypothyroidism** ☐**hyperthyroidism** ______________________________

Hematologic/Lymphatic: ☐**anemia** ☐**leukemia** ☐**Lyme disease** ______________________________

Allergic/Immunologic: ☐**HIV** ☐**lupus** ☐**immune disorder** ______________________________

☐**Seasonal or environmental allergies** ______________________________

If you have Diabetes, when were you diagnosed?_____________what was your last A1C %? ___________
When was it last taken?____________ If you have Sleep Apnea, do you use a CPAP machine?____________

☐**Glaucoma**
☐**Cataracts**
☐**Retinal Disease**
☐**AMD/Macular Degeneration**
☐ **Floaters in vision**
☐ **Flashes in vision**
☐ **Headaches**
☐ **Double vision**

☐**Eye Injury**
☐**Blindness**
☐**Eye turn or crossed eye, patching therapy**
☐**Diabetic Retinopathy**
☐**Dry Eye**
☐**Retinal Detachment**
☐**History of eye surgery; if so, for what?**
____

OVER ⟶

ANY OTHER MEDICAL CONDITIONS NOT LISTED ON PREVIOUS PAGE_________________

____

What medications do you take regularly including eye drops and vitamins?________________________

____

Are you **allergic** to any medications? ☐Yes ☐No If yes, please **list:** ________________________________

☐**Glasses** ☐**Contacts**

Family Medical History: Has any of your **immediate** family had? **If yes,** WHO?

Condition			If yes, WHO?
Glaucoma	Yes	No	_______________________________
Cataracts	Yes	No	_______________________________
AMD/Macular Degeneration	Yes	No	_______________________________
Retinal Disease	Yes	No	_______________________________
Blindness	Yes	No	_______________________________
Eye turn, crossed eye, or lazy eye	Yes	No	_______________________________
Diabetes	Yes	No	_______________________________
Cancer	Yes	No	_______________________________
Heart Disease	Yes	No	_______________________________
Hypertension	Yes	No	_______________________________
Kidney Disease	Yes	No	_______________________________
Stroke	Yes	No	_______________________________
Arthritis	Yes	No	_______________________________
Other	Yes	No	

If yes, please list____________________________

Please check if you are feeling any of these symptoms **today**:

Fatigue _____ Depressed_____ Chest Pain _____ Dry Eye_______
Vertigo _____ Anxious_____ Joint Pain _____
Shortness of breath___ Headache _____ Seasonal or Environmental Allergies_____

Height___________ Weight________

Do you smoke? Yes☐ No☐ **If no, have you ever smoked?** Yes☐ No☐

In case of Emergency whom may we contact? Name(s):____
Relationship:_______________________________________
Phone(s): ____

How did you hear about Jordan Family Eyecare?

☐ Facebook ☐ Google ☐ Website ☐ Radio ☐ Instagram Other_____________________________________