Welcome to Rolling Hills Eyecare

Please take a moment to provide the following information. Thank you.

Last name_____First _____MI_____Birthdate_____
Information about person financially responsible for charges incurred, if not patient (eg. parent or guardian):
Name: _____ Date of Birth: _____
Address: _____City _____ State _____ Zip _____
Telephone (day)_____

Insurance Information (please allow us to make a copy of your insurance card)
Insurance carrier _____ Subscriber's name _____
Subscriber's date of birth _____ Patient ID# _____
Government regulations require we ask you the following :
√ Which race and ethnicity best describe you?

Race	Ethnicity
√ American Indian or Alaska Native	√ Hispanic or Latino
√ Asian	√ Not Hispanic or Latino
√ Black or African American	√ Unknown
√ Native Hawaiian or Pacific Islander	√ Decline to answer
√ White	
√ Other race	
√ Decline to answer	

√ What is your primary language? _____ √ Decline to answer
√ What is your marital status? √ Single √ Married √ Divorced √ Widowed √ Decline to answer
In case of emergency who should we contact?
Name _____ Relationship _____
Daytime phone _____
Which of the following best describes your smoking history?
√ Current every day smoker √ Former smoker
√ Current some day smoker √ Never a smoker
√ Smoker
Do you drink alcohol? NO YES how often?_____Use other substances? NO YES what? _____

Vision Needs Assessment
What is your occupation? _____
How do you use your eyes in your job? (Indicate estimated hours per day as applicable)
Laptop computer _____ Desktop computer _____ Handheld devices _____ Driving _____ Outdoors_____
Paperwork _____ Lecturing _____ Shopwork _____ Other _____ please indicate _____
What activities occupy your non-work time?
Sports: cycling running swimming golf tennis baseball/softball basketball others _____
Outdoor activities: hunting fishing boating shooting hiking gardening others _____
Indoor activities: sewing crafting reading computer use TV woodworking shop work others _____

Other:

_____

_____

Medical and Eye Information

Personal Eye Information

Date of last eye exam _____

Do you wear glasses? NO YES Type single vision progressive flat top bifocal reading sun

Do you wear contact lenses? NO YES

Type_____

Have you had any eye operations? NO YES Type_____ Date _____

Have you had any eye injuries? NO YES Type _____

Date_____

Have you been diagnosed w/glaucoma? NO YES

cataracts? NO YES

macular degeneration? NO YES

other eye conditions? NO YES Type

_____

Personal Medical Information

Name of primary care doctor _____ Date of last visit _____

Do you have health concerns in any of the following areas? If yes, please explain.

Heart NO/YES

☐_____

Blood Pressure NO/YES

_____

Breathing

NO/YES_____

Stomach/Digestive

NO/YES_____

Ears/Nose/Throat

NO/YES_____

Urinary NO/YES

_____

Muscles/Bones

NO/YES_____

Skin

NO/YES_____

Blood/Lymph

NO/YES_____

Glands

NO/YES_____

Diabetes

NO/YES_____

Have you had any:
Medication allergies NO/YES To what? _____ What happens? _____
Other allergies NO/YES To what? _____ What happens? _____
Other health problems NO/YES What? _____
Surgeries (last 3 yrs) NO/YES What? _____
Please list your current medications: _____
(or bring list) _____

Family Medical Information

Do your blood relatives have any of the following?
High blood pressure NO/YES who? _____ Macular Degeneration NO/YES who? _____
Diabetes NO/YES who? _____ Retinal Detachment NO/YES who? _____
Glaucoma NO/YES who? _____ Cataracts NO/YES who? _____
Other eye conditions NO/YES what? _____