Welcome to Rolling Hills Eyecare

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

Last name_____First _____MI_____Birthdate_____
Address _____ City _____ State _____ Zip _____
Phone (home)_____ (work) _____ (cell) _____
Email: _____ (please print clearly)
By what method would you prefer us to contact you? (eg appointment confirmations, glasses ready etc…)
☐ Text ☐email ☐Text and email ☐ I don't use text or email, please contact me by phone
(☐ home ☐ work ☐ cell)
May we mail you a postcard when it is time for your next annual vision and health exam? ☐ YES ☐NO

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?_____

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?

Stomach/Digestive	NO/YES	Urinary	NO/YES	Mental	NO/YES
Ears/Nose/Throat	NO/YES	Muscles/Bones	NO/YES	Glands	NO/YES
Heart	NO/YES	Blood/Lymph	NO/YES	Breathing	NO/YES
Skin	NO/YES	Blood Pressure	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: _____

_____

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? _____

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: _____