# 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)____________________________________

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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# __________________________________________

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Government regulations require we ask you the following :

◈ Which race and ethnicity best describe you?

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other race
- ☐ Decline to answer

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to answer

◈ What is your primary language? ______________________ ☐ Decline to answer

◈ What is your marital status? ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Decline to answer

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In case of emergency who should we contact?

Name ________________________________________ Relationship ________________________________

Daytime phone ________________________________

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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?________

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**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? ____________