www.InSightEyeCareHouston.com
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Welcome to InSight EyeCare

We are pleased to welcome you to our practice. Please fill out this form as completely as you can so that we may provide you with a more comprehensive and personalized level of care. We look forward to working with you in maintaining your health.

Today's date: ______________________

PATIENT INFORMATION

NAME □ Mr. □ Miss □ Mrs. □ Ms. □ Dr. ____ DOB ________________
Last Name First Name MI Nickname

SSN ________________

ADDRESS ____ GENDER □ Male □ Female

CITY________________________ STATE ______ ZIPCODE _____________ MARITAL STATUS □ Single □ Married

CELL PHONE ______________________ WORK PHONE _____________________ HOME PHONE _____________________

EMAIL ____

PREFERRED METHOD OF CONTACT: □ Cell □ Work □ Home □ Text □ Email

EMPLOYMENT STATUS □ Retired □ Employed □ Unemployed IF STUDENT: □ Full time □ Part time GRADE/ SCHOOL: _____________________

OCCUPATION ______________________________EMPLOYER ______________________________

Please list family members we've seen: ____

REFERRED BY: □ Location □ Internet □ Insurance □ Other: ___________________ □ Direct referral: ___________________

INSURANCE: Please provide ALL insurance information for proper filing & payment. Many eye problems are covered by your health insurance

VISION INSURANCE PLAN ______________________________ ID# __________________ Group# _____________

What is your relationship to Primary Insurance Member □ Self □ Spouse □ Dependent

If not Self: Member Name ______________________________ Member SSN ______________________

Member Employer ______________________________ Member DOB ______________________

PRIMARY MEDICAL INSURANCE ______________________________ ID# __________________ Group# ___________

What is your relationship to Primary Insurance Member □ Self □ Spouse □ Dependent

If not Self: Member Name ______________________________ Member SSN ______________________

Member Employer ______________________________ Member DOB ______________________

SECONDARY MEDICAL INSURANCE ____________________________ ID# __________________ Group# ___________

SOCIAL HISTORY

Tobacco Use: □ Never Smoked
□ Current Smoker: Packs per day _________
□ Former smoker: Year stopped __________

Alcohol Use: □ None
□ Social Use Only
□ Drinks per week _______

Narcotic Use:
□ None
□ Recreational ________________

SPECTACLE STATUS

□ I do not currently wear glasses

□ I currently wear glasses: ○ Prescription ○ Over the Counter
When do you wear them? ○ Full Time ○ Part Time ○ Distance Only ○ Reading Only

CONTACT LENS STATUS

Have you worn contacts? □ Yes □ No Do you currently wear contacts? □ Yes □ No Are you interested in contacts? □ Yes □ No
Type of contacts recently worn: □ Soft/ Disposable □ Hard/GP □ Toric (for astigmatism) □ Color □ Bifocal □ Monovision
Discard how often? __________________ Do you sleep in your contacts? □ Yes □ No If yes, # of nights in a row: ____________
What lens care system do you use? __________________________ Please list any lens care solution allergy __________________

EYE HEALTH HISTORY/ History of present illness

Date of last eye exam: ____________________ Doctor's Name ____________________

Please Mark ALL conditions that you may be experiencing:

Ocular Complaints:
- □ Double Vision
- □ Flashes of light
- □ Floaters
- □ Headaches

Vision Complaints:
- □ Distance blurry
- □ Near blurry
- □ Computer blurry
- □ Loss of Vision

Ocular Symptoms:
- □ Eye fatigue
- □ Eye Pain
- □ Dry, sandy feeling
- □ Redness
- □ Burning
- □ Itching
- □ Watery Eyes
- □ Photophobia/ Light sensitivity
- □ Infection
- □ Mucous/discharge

Contact Lenses:
- □ Excessive discomfort
- □ Dryness
- □ Lens movement
- □ Fogging

Other: ____________________

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____

OCULAR HISTORY & FAMILY OCULAR HISTORY: Please indicate if ANY of the conditions apply to you or a family member

	YOU	FAMILY		YOU	FAMILY		YOU	FAMILY
Bell's Palsy	□	□	Eye Turn	□	□	Macular Degeneration	□	□
Blindness	□	□	Glaucoma	□	□	Optic Neuritis	□	□
Cataract	□	□	Iritis	□	□	Retinal Disease	□	□
Chalazion/Styes	□	□	Keratoconus	□	□	Trauma, Ocular	□	□
Eye Infection	□	□	Lazy Eye	□	□	Tumor, Ocular	□	□

Other ocular history, please list (type & year): ____________________

i.e. Injuries and Eye surgeries

OCULAR MEDICATIONS: Please list ANY over the counter and/or prescription eye drops you are using.

Eye Drop(s):

____

ORAL/SYSTEMIC MEDICATIONS: Please list ANY over the counter and/or prescription medications you are taking.

Medications:

____

____

____

DRUG ALLERGIES:

____

SYSTEMIC FAMILY HISTORY/ REVIEW OF SYSTEMS:

		YOU	FAMILY
Cardio	Cardiovascular disease	□	□
	Hypertension	□	□
	Stroke	□	□
	Heart attack	□	□
Resp	Asthma	□	□
	Lung Cancer	□	□
	COPD	□	□
	Sarcoidosis	□	□
Gastro	Hepatitis	□	□
	Colon Cancer	□	□
	Colitis	□	□
	Ulcers	□	□

		YOU	FAMILY
Muscu	Arthritis	□	□
	Rheumatoid Arthritis	□	□
	Myasthenia Gravis	□	□
Skin	Skin cancer	□	□
	Acne Rosacea	□	□
Neuro	Multiple Sclerosis	□	□
	Headaches	□	□
	Migraines	□	□
Psych	Anxiety	□	□
	Depression	□	□
	Bipolar	□	□

		YOU	FAMILY
Endo	Diabetes	□	□
	Thyroid disease	□	□
Blood	Elevated cholesterol	□	□
	Anemia	□	□
	Sickle cell	□	□
Immuno	Lupus	□	□
	HIV	□	□
	AIDS	□	□
OB	Pregnant	□	
	Nursing	□	

Other Medical History: ____________________

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