EYESITE
EyeSiteTexas.com

Dr. Kevin B. Harrison & Dr. John D. O'Neill

Therapeutic Optometrists, Optometric Glaucoma Specialists

Doctor:_____

Date: _____

Patient Information:

Patient's Name_____ Date:_____

Parent or Guardian_____ Patient's DOB:_____

Mailing Address _____ Home Phone # (_____)_____

_____ Work Phone # (_____)_____
(City) (State) (Zip Code)

Cell Phone # (_____)_____

E-mail Address _____ Occupation_____

Employer or School (if patient is a student)_____ Grade _____

How did you find out about our office? _____

My visit today is for: Routine Care Glasses Contact Lenses Office Visit Other

Other (please explain)_____

Do you currently wear contact lenses? Yes No If so, what type_____

Insurance: *Due to billing requirements, all insurance information must be provided to our office prior to your examination and/or the ordering of any ophthalmic materials.*

Vision Provider_____ Medical Provider_____

Patient SSN (If using insurance): _____ Insurance ID #_____

Insurance Policy # / Group #:_____

Primary Cardholder Name:_____ Relationship to Patient:_____

Primary Cardholder SSN:_____ Primary Cardholder DOB:_____

Do you participate in Medical Flex Spending? Yes No ***(All Rx Eyewear, Contacts, & Exam Fees qualify)***

Social History:

Do you drink alcohol? No Yes Type / Amount _____

Do you use tobacco products? No Yes Type / Amount _____

Do you use illegal drugs? No Yes Type / Amount _____

Medical History:

Are you pregnant and/or nursing at this time? Yes No

List any health problems: _____

_____

_____

Are you taking any medications (including eye drops and over-the counter) and what for? Yes No

_____

_____

Are you allergic to any medications? Yes No

(if so, please list) _____

Eye History:

Eye injuries Yes No
(foreign objects, black eye, etc.)

Eye disease Yes No
(cataract, glaucoma, macular degeneration, etc.)

Eye surgery Yes No
(cataract, laser vision correction, etc.)

Please Explain_____

_____

_____

Is there a history of Eye Disease in your Family? Yes No

Please Explain:_____

_____

Review of Systems:

Do you currently, or have you ever had any problems in the following areas?

Eyes (Ocular symptoms)		
Eye pain or soreness	Yes	No
Fatigue/tired eyes	Yes	No
Dry/gritty feeling	Yes	No
Redness	Yes	No
Burning	Yes	No
Itching	Yes	No
Excess watering	Yes	No
Mucous discharge	Yes	No
Chronic infections	Yes	No
Squinting	Yes	No
Glare/light sensitivity	Yes	No
Halos around lights	Yes	No
Double vision	Yes	No
Loss of vision	Yes	No
Blurred vision	Yes	No
Flashes	Yes	No
Floaters	Yes	No
Constitutional		
Fever	Yes	No
Weight loss or gain	Yes	No
Skin		
Rosacea	Yes	No
Metal allergies	Yes	No
Ear, Nose, Throat, Mouth		
Allergies/hay fever	Yes	No
Sinus infections	Yes	No
Hearing Loss	Yes	No
Respiratory		
Asthma	Yes	No
Chronic bronchitis	Yes	No
Emphysema	Yes	No
Vascular/Cardiovascular		
Heart disease/problems	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Stroke	Yes	No
Gastrointestinal		
Acid reflux	Yes	No
Intestinal problems	Yes	No
Liver/spleen problems	Yes	No
Endocrine		
Thyroid/other glands	Yes	No
Diabetes	Yes	No
Genitourinary		
Genitals/kidney/bladder	Yes	No
Lymphatic/hematologic		
Anemia	Yes	No
Bleeding	Yes	No
Bones/joints/muscles		
Rheumatoid arthritis	Yes	No
Muscle/joint pain	Yes	No
Neurological		
Headaches	Yes	No
Seizures	Yes	No
Alzheimer's	Yes	No
Parkinson's	Yes	No
Psychiatric	Yes	No
Immune system	Yes	No

I acknowledge that I have received or read a copy of Eye Site's (the "Provider") Notice of Privacy Practices

Patient Name (Please Print)_____ Signature_____ Date_____