NORMAN PROFESSIONAL EYECARE

Norman Professional Eye Care 21B Doctor's Park, Cape Girardeau, MO 63703

_____ _____, _____ _____
First name: (MI) Last (Parent name if Patient is a minor)

_____, _____, _____ _____
Address / Street City State Zip

Social Security # (for insurance purposes) _____ Date of Birth _____
How did you hear about our office? _____

Home phone: _____
Work phone: _____
Cell phone: _____
Email: _____
Primary care physician _____
Preferred Pharmacy:_____
Medical Insurance: _____
Vision Insurance: _____
Do you have CARE CREDIT? Y or N

Ethnicity:
☐Hispanic / Latino
☐Not Hispanic / Latino

Preferred language:
_____

Race:
☐White
☐Black or African American
☐Asian
☐Hawaiian or Pacific Island native
☐American Indian or Alaska native
☐Hispanic / Latino
☐Other: _____

Health History

General Health:
☐ Developmental disability
☐ Cancer
☐ Fatigue syndrome
Other: _____

ENT:
☐ Hearing loss
☐ Sinusitis
☐ Dry mouth
☐ Laryngitis
Other: _____

Neuro:
☐ MS
☐ Epilepsy
☐ Cerebral palsy
☐ Tumors
☐ Stroke/CVA
☐ Migraines
Other: _____

Psych:
☐ Depression
☐ ADD
☐ Anxiety Disorder
☐ Bipolar
Other: _____

Cardio:
☐ Hypertension
☐ Stroke/CVA
☐ Heart disease
☐ Vascular disease
☐ Congestive heart failure
Other: _____

Respiratory:
☐ Cigarette smoker
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic obstruction
☐ Sleep apnea
Other: _____

Gastrointestinal:
☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Acid reflux
☐ Celiac disease
Other: _____

Genitourinary:
☐ Kidney disease
☐ Prostate disease/cancer
☐ STD: Herpes/Chlamydia
☐ Benign prostate hypertrophy
☐ Pregnant
☐ Nursing
Other: _____

Muscular/skeletal:
☐ Arthritis
☐ Osteoarthritis
☐ Fibromyalgia
☐ Muscular dystrophy
☐ Ankylosing spondylitis
☐ Osteoporosis
☐ Gout
Other: _____

Skin/Connective tissue:
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes simplex /cold sores
☐ Herpes zoster /shingles
Other: _____

Endocrine:
☐ Type 2 Diabetes Mellitus
☐ Type 1 Diabetes Mellitus
☐ Thyroid dysfunction
☐ Hormone dysfunction
Other: _____

Hematology/Lymph:
☐ Anemia
☐ Large volume blood loss
☐ Ulcer
☐ Hypercholesteremia
Other: _____

Allergy/Immune:
☐ Drug allergies
☐ Environmental allergies
☐ Rheumatoid arthritis
☐ Lupus
☐ Sjogren's syndrome
Other: _____

Please list your current medications (or give list to receptionist)

Drug Name	Dose (25mg)	Taken how often? (1-daily)	Treat for? (blood pressure, etc.)

(Continued)

Over-the-counter medications used: _____

Medications allergic to: _____

Other allergies: ☐ spring ☐ fall ☐ year round ☐ dust ☐ latex ☐ food allergies

Eye history:

☐ Glaucoma
☐ Glaucoma suspect
☐ Cataract
☐ Age-related macular degeneration
☐ Surgery: Eye(s)? _____ Date(s)? _____
☐ Patching
☐ Inflammatory disorder
☐ Strabismus
☐ Amblyopia
☐ Retinal degeneration
☐ Retinal hole
☐ Retinal detachment
☐ Keratoconus
☐ Injury: Describe: _____
_____
☐ Dry eye(s)
☐ Nystagmus
☐ Other: Describe:_____

Social history:

Do you consume alcohol?
☐ Yes, How much per week: _____
☐ No
Do you use tobacco?
☐ Never
☐ Used to but quit
☐ Yes: How much per day: _____
Type: ☐ cigarettes ☐ cigar ☐ pipe ☐ smokeless tobacco ☐ other

Place of Employment / School _____
Type of work done _____ Time using screen devices :_____
(tv / phone / tablet /computer)
What do you do when you are ***NOT*** working? Hobbies /Activities? _____
_____

Family medical and eye history:

	Dad	Mom	Brother	Sister	Son	Daughter	Other relative	Unknown
Cancer:	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes, type1 (kids):	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes, type2 (adults):	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension:	☐	☐	☐	☐	☐	☐	☐	☐
Hyperthyroid (high):	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroid (low):	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts:	☐	☐	☐	☐	☐	☐	☐	☐
Macular degeneration:	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma:	☐	☐	☐	☐	☐	☐	☐	☐
Other loss of eyesight:	☐	☐	☐	☐	☐	☐	☐	☐