# Welcome to Master Eye Associates

**Please Print**

Last Name: _____ First Name_____ Middle Initial _____
Address: _____ City: _____ State: _____ Zip: _____
D.O.B: _____-_____-_____ Age: _____ Sex: M / F SS#: _____-_____-_____ Home #_____
Cell #_____ Employer: _____Occupation: _____
E-mail: _____ (We do not share your email with anyone)

## Vision/Medical Insurance

Name of Policy Holder: _____D.O.B: _____-_____-_____ SS#_____-_____-_____
Vision Insurance: _____ Subscriber# _____Grp#_____
Medical Insurance: _____ Subscriber# _____Grp#_____

For new patients--how did you hear about us? ☐Walk-by/drive by ☐Advertising (specify)_____
Referred by whom? _____
Approximate date of last eye exam? _____ Name of previous eye doctor? _____
Do you wear glasses? Y / N Contact Lenses? Y / N Hobbies or special visual needs: _____
Approximate hours of computer use per day? _____
Do you want to learn about new options to reduce or eliminate your dependence on eyeglasses? Yes / No

## Your Reason for Visiting Our Office Today (Please check all that apply)

**Vision Reason**

☐ No complaints-Wellness check
☐ Want new eyeglass prescription
☐ Want new prescription for contact lenses
☐ Consultation for Refractive Surgery

**Medical Eye Problems**

☐ Blurred far vision
☐ Blurred near vision
☐ Eyes fatigued/Irritated
☐ Discharge or watery eyes
☐ Glare/light sensitive
☐ Halos/distorted vision
☐ See spots or light flashes
☐ Eye Pressure
☐ Eyes itch
☐ Eyes Red
☐ Eyes burn
☐ Headaches
☐ Eyes feel dry
☐ Eyelid problem/stye
☐ Re-check eye disease/disorder
☐ Glaucoma evaluation check-up
☐ Diabetic eye exam

## Patient History (Please check all that apply)

**Allergic/Immunologic**
☐Environmental allergy
☐Lupus
☐Rheumatoid arthritis
**Cardiovascular**
☐Heart disease
☐High blood pressure
☐Stroke
☐Vascular disease(PAD)
**Constitutional**
☐Fatigue
☐Fever
☐Weight loss
**Ears, Nose, Throat**
☐Hard of hearing
☐Respiratory infection
☐Chronic cough

**Endocrine**
☐insulin dependent diabetes
☐non-insulin dependent diabetes
☐Thyroid dysfunction
**Eyes**
☐Amblyopia (lazy eye)
☐Cataracts
☐Eye Surgery_____
☐Glaucoma
☐Macular degeneration
☐Retinal detachment
☐Strabismus
**Gastrointestinal**
☐Colitis
☐Crohn's
☐Stomach ulcer

**Genitourinary**
☐ Kidney or bladder disorder
☐STD
**Hematologic/ Lymphatic**
☐Anemia
☐High Cholesterol
☐Leukemia
**Integumentary/Skin**
☐Eczema
☐Psoriasis
☐Rosacea
**Neurological**
☐Epilepsy
☐Headaches/ Migraines
☐Multiple sclerosis
☐Seizures

**Musculoskeletal**
☐Ankylosing spondylitis
☐Fibromyalgia
☐Joint pain / osteoarthritis
☐Osteoporosis
**Psychiatric**
☐Dementia
☐Depression
☐Panic disorders
**Reproductive**
☐Pregnant
**Respiratory**
☐Asthma
☐COPD
☐Emphysema
☐Smoker
**Cancer** (Type/Year diag.)
_____

Please list any drug allergies: _____
Your current medications: _____

**Family History** (If yes, please list the family member)

Diabetes Y / N_____ Heart Disease Y / N_____ Cataract Y / N_____ Macular degeneration Y / N_____
Cancer Y / N_____ Hypertension Y / N_____ Glaucoma Y / N_____

**Social History**

Do you use tobacco products? Y / N If yes, type/amount/how long: _____
Do you drink alcohol? Y / N If yes, type/amount/how long: _____
Do you use illegal drugs? Y / N If yes, type/amount/how long: _____

Thank you for the privilege of allowing us to care for your vision and medical eye care needs. MasterEyeAssociates.com