CORTLANDT EYE CARE

HEALTH HISTORY AND INSURANCE FORM

Today's date (*mm/dd/yyyy*) _____

Patient's name _____ Gender: Male ○ Female ○

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

E-mail address _____

Who can we thank for referring you? _____

D.O.B. (*mm/dd/yyyy*) _____ Social Security Number _____

Occupation _____

Name of Employer _____ City _____

Marital Status: Married ○ Single ○ Divorced ○ Separated ○ Widowed ○

Please check if you have ever had any of the following:

Diabetes ☐ Cataracts ☐ Lazy eye ☐ High blood pressure ☐

Glaucoma ☐ Allergies ☐ Eye infections ☐ Macular degeneration ☐

Do you currently smoke? Yes ○ No ○

List any other medical issues _____

Who is your family physician? _____

Previous eye doctor _____ Date of last eye exam: (*mm/yyyy*) _____

Special visual demands (work or hobby) _____

Have you ever had injury or surgery to your eyes? If so, please describe: _____

_____

Have any bloodline relatives had glaucoma or other loss of sight? _____

List all medications you are currently taking: _____

Are you allergic to any medications? Please list _____

Do you currently wear glasses? Yes ○ No ○ How old are they? _____

When do you wear them? _____

Do you presently wear contact lenses? Yes ○ No ○

If yes, please select: Hard ○ Soft ○ Gas Permeable ○ Disposable ○

How old are the contacts? _____ Brand _____

If no, have you ever worn contacts? Yes ○ No ○

Do you have ***vision*** care insurance? Yes ○ No ○

Name _____ ID#_____

Do you have ***health care*** insurance? Yes ○ No ○

Name _____ ID#_____

PRINT RESET