Welcome To Delaware Eyes

NAME:____ Nickname/Preferred name:_______________
(First) (Last) (Middle)

DATE:______________ **Reason for today's visit:**____

Birth Date:___/____/_____ Gender: Male Female Nonbinary
Address:____
City: _______________________State:___________ Zip:________________
Home phone number: ______________________Cell:____________________
Email Address:____________________________________
Circle your preferred method of communication: Home phone Cell phone Text Email
Occupation:__________________________________
Emergency Contact Name:______________________ Relationship:_____________________
Emergency Contact number:_____________________
Is this person authorized to receive personal medical information? YES NO

Insurance information:

Vision Insurance:
VSP EyeMed Superior Other:___________________
Policy holder's information* Name:____________________________ DOB:_______ Last 4 SSN:_______
(First) (Last)
Medical Insurance: Anthem Cigna Humana Medical Mutual Medicare
Other:_______________
Policy holder's information* Name:________________________________ DOB:__________
(First) (Last)
Policy/ID number: ____________________________ Group number:________________

Primary Care Physician:_______________________ **Preferred Pharmacy:**_________________

Medication list (prescription, OTC, Supplements) * **If you have a list, we would be happy to make a copy***

____

____

Please list ANY allergies (including food, environmental, drug and latex): ______________________________
____

<u>OCULAR HISTORY:</u> Do you currently have,or have you had, any of the following? (Circle ALL that apply)

Blurred Vision	Glaucoma Suspect	Strabismus (cross eyed)	Dry eyes (burn/watery)
Loss of Vision	Glaucoma	Amblyopia (lazy eye)	Tired Eyes
Double Vision	Cataracts	Nystagmus (uncontrolled movement)	Headaches
Flashes of light	Macular Degeneration	Keratoconus	Itchy Eyes
Halos/Glare	Retinal Detachment	Eye Injury______________	Light Sensitivity
Floaters	Inflammatory Disorder	Eye Surgery____________	Other____________

Do you wear glasses? Yes No **Do you wear Contact Lenses?** Yes No **Are you interested in contacts?** Yes No

Average hours/day of computer/digital device screen time(Circle one) : 0-2 2-5 5-10 10+

 PLEASE COMPLETE PAGE 2

MEDICAL HISTORY: **Do you currently have, or have you had, any of the following?**

(Circle ALL that apply OR if nothing is applicable, please circle NONE)

CONSTITUTIONAL/Well-Being
Developmental Disabilities
Cancer (type)___________
Fatigue Syndrome
Other_________________
NONE

Ear/Nose/Throat
Hearing Loss
Sinitus
Dry Mouth
Laryngitis
Other___________
NONE

Neurological
Multiple Sclerosis
Epilepsy
Stroke/CVA
Migraine
Autism Spectrum Disorder
Other_______________
NONE

Psychiatric
Depression
Attention Deficit
Bipolar
Anxiety
Other__________
NONE

Cardiovascular
High Blood Pressure
Stroke
Heart Disease
Vascular Disease
Congestive Heart Failure
Other______________
NONE

Respiratory
Smoker /Former Smoker
Asthma
Bronchitis
Emphysema
COPD
Sleep Apnea
Other ________
NONE

Gastrointestinal
Crohn's Disease
Colitis
Ulcer
Acid Reflux
Celiac Disease
Other______________
NONE

Genitourinary
Kidney Disease
Prostate Disease/Cancer
STD(Chlamydia/Herpetic)
Pregnant/Nursing
Other__________
NONE

Musculoskeletal
Arthritis
Osteoporosis
Osteoarthritis
Fibromyalgia
Muscular Dystrophy
Gout
Ankylosing Spondylitis
Other______________
NONE

Integumentary
Eczema
Rosacea
Psoriasis
Shingles/ Herpes Zoster
Cold Sores/ Herpes Simplex
Other___________
NONE

Hematologic/Lymphatic
Anemia
Large volume blood loss
Ulcer
High Cholesterol
Other______________
NONE

Allergic/Immunologic
Rheumatoid Arthritis
Sjogren's Syndrome
Environmental Allergies
Lupus
Other_____________
NONE

Endocrine
Type I Diabetes*
Type II Diabetes*
Pre-Diabetes/Borderline Diabetes
Thyroid Dysfunction
Hormonal Dysfunction
OTHER __________
NONE

***Diabetic patients only:**
Year Diagnosed _______
Last A1C_____________
Fasting BG (avg)______
NAME of PROVIDER
managing your diabetes:
____
____

SOCIAL HISTORY (ALL patients please complete)
Tobacco use: Yes No
If yes, type(cigarettes,smokeless,etc)___________
Amount per day_______________
Alcohol use: Yes No
Drinks per week_______________
HOBBIES:___________________________________
(to help us better understand your vision needs)

FAMILY MEDICAL & OCULAR HISTORY (Circle ALL that apply):
Please include information for all biological/blood relatives (including parents, grandparents, siblings, aunt,uncles)

MEDICAL
High Blood Pressure
Diabetes
Cancer
Thyroid
Other______________

OCULAR
Cataracts
Glaucoma
Macular Degeneration
Amblyopia (Lazy Eye)
Strabismus
Retinal Detachment/Retinal Hole
Dry Eyes
Nystagmus (involuntary eye movements)
High/Severe Myopia
Other___________________

☐ *Check here if Family Medical History is UNKNOWN*

Patient Name printed : ____
Patient or **Parent/Guardian** signature:______________________________ Date:___________________