# EYE CONSULTANTS
## OF RHODE ISLAND

Welcome to our Office! Thank you for choosing our practice for your eye care needs.

### Patient Information

Name: _____ DOB: _____ Today's Date _____

Address: _____ Social Sec# _____

_____ Gender ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Appointment Reminder By: ❑ Text Message ❑ Cell ❑ Home

Occupation: _____ Employer _____

Spouse Name (Parent if Minor) _____ Spouse/ Parent Phone # _____

Emergency Contact: _____ Tel #: _____ Relationship: _____

Primary Care Physician: _____ Tel #: _____

Referring Physician: _____ Tel #: _____

Preferred Pharmacy Name/Location: _____

How did you hear about Eye Consultants of RI? _____

### Insurance Information (complete only if you are <u>not</u> the subscriber)

Subscriber Name _____ Relationship to Patient _____

Social Sec#: _____ DOB: _____

Address: _____ Employer: _____

**Primary Insurance Company:** _____ -_____ Effective Date: _____

ID# _____ Group # _____

**Secondary Insurance Company:** _____ Effective Date: _____

ID# _____ Group # _____

## Medical Information

**Medical History** (please check Yes only if there is a current diagnosis of the following)

| | | | | | |
|---|---|---|---|---|---|
| Anxiety/Depression | ❑ Yes ❑No | Heart Disease | ❑ Yes ❑No | Lung Disease | ❑ Yes ❑No |
| Arthritis | ❑ Yes ❑No | Pacemaker/Defibrillator | ❑ Yes ❑No | Lupus | ❑ Yes ❑No |
| Asthma | ❑ Yes ❑No | Hepatitis/ type _____ | ❑ Yes ❑No | Migraines | ❑ Yes ❑No |
| Bleeding Disorder | ❑ Yes ❑No | High Blood Pressure | ❑ Yes ❑No | MRSA | ❑ Yes ❑No |
| Cancer type | ❑ Yes ❑No | High Cholesterol | ❑ Yes ❑No | Multiple Sclerosis | ❑ Yes ❑No |
| type _____ | | HIV/AIDS | ❑ Yes ❑No | Sleep Apnea | ❑ Yes ❑No |
| Diabetes | ❑ Yes ❑No | Kidney Disease | ❑ Yes ❑No | Stroke | ❑ Yes ❑No |
| Environmental Allergies | ❑ Yes ❑No | Latex Allergy | ❑ Yes ❑No | Thyroid Disease | ❑ Yes ❑No |
| Hearing Loss | ❑ Yes ❑No | Liver Disease | ❑ Yes ❑No | Tuberculosis | ❑ Yes ❑No |
| | | | | Other: _____ | |

Alcohol Usage: ❑ None ❑ Social ❑ Moderately ❑ Heavy

Cigarette Smoking: ❑ No ❑ Yes ❑ Quit (when) _____

**Personal Eye Information**

| | | | |
|---|---|---|---|
| Amblyopia (lazy eye) | ❑ Yes ❑No | Macular Degeneration | ❑ Yes ❑No |
| Glaucoma | ❑ Yes ❑No | Dry Eyes | ❑ Yes ❑No |
| Cataracts | ❑ Yes ❑No | Do you wear contact lenses? | ❑ Yes ❑No |

**Past Surgeries Including Eye Surgeries** (note year)

_____

_____

**Medication Allergies** (please list):

_____ Reaction _____ _____ Reaction _____

_____ Reaction _____ _____ Reaction _____

_____ Reaction _____ _____ Reaction _____

**Family History** (please check all that apply and indicate which family members):

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Amblyopia | ❑mom | ❑dad | ❑sibling | ❑grandparent | Heart Disease | ❑mom | ❑dad | ❑sibling | ❑grandparent |
| Cancer | ❑mom | ❑dad | ❑sibling | ❑grandparent | High Blood Pressure | ❑mom | ❑dad | ❑sibling | ❑grandparent |
| Crossed Eyed | ❑mom | ❑dad | ❑sibling | ❑grandparent | Macular Degeneration | ❑mom | ❑dad | ❑sibling | ❑grandparent |
| Diabetes | ❑mom | ❑dad | ❑sibling | ❑grandparent | Retinal Detachment | ❑mom | ❑dad | ❑sibling | ❑grandparent |
| Glaucoma | ❑mom | ❑dad | ❑sibling | ❑grandparent | Retinitis Pigmentosa | ❑mom | ❑dad | ❑sibling | ❑grandparent |

**Review of Systems**

(please cirlcle all symptoms which the patient has currently, or has had recently. Circle NO if none has occurred):

| | | | | | |
|---|---|---|---|---|---|
| General: (ex: unintentional weight change) | NO | YES | Ear, Nose, Throat: (ex: hearing loss, snoring, dizziness) | NO | YES |
| Cardiovascular: (ex: chest pain, irr. heartbeat) | NO | YES | Respiratory: (ex: wheezing, shortness of breath) | NO | YES |
| Brain/ Nervous System: (ex: numbness, seizures) | NO | YES | Blood/Lymph Nodes: (ex: anemia, excessive bleeding) | NO | YES |
| Gastrointestinal: (ex: reflux, nausea, vomiting) | NO | YES | Allegies: (ex: hives, severe reaction to insect bites) | NO | YES |
| Psychiatric: (ex: anxiety, depression) | NO | YES | Skin: (ex: masses, lesions) | NO | YES |
| Bone, Joint, Muscle: (ex: pain, arthritis, cramps) | NO | YES | Endocrine: (ex: thyroid dysfunctyion) | NO | YES |