EYECARE ASSOCIATES
OF LEE'S SUMMIT

Patient Welcome Form

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form, front and back sides. If you have questions or need assistance we would be glad to help you.

Patient Name: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. _____ Today's Date: ___/___/___
Address: _____ Home phone: _____
_____ Work phone: _____
Parent/Guardian (if applicable): _____ Cell phone: _____
Spouse (if applicable):_____ Email address: _____
Birth date: ___/___/___ Social Security #: __ __ __-__ __- __ __ __ __ Occupation: _____
Employer: _____
Name of Medical Doctor: _____ Last physical exam: ___/___/____
Name of any other specialty physician monitoring your care: _____
Name of Previous Optometrist (if applicable):_____ Last eye exam: ___/___/____
How did you hear about our practice? _____

MEDICAL HISTORY

Do you have any allergies to medications? ❑ Yes ❑ No If yes, which medications? _____
Please list any medications you take and reason for use in the space provided below or provide the receptionist with a current list.
List all major injuries, surgeries and/or hospitalizations you have had: _____
_____
Are you pregnant and/or nursing? ❑ No ❑ Yes If yes, how far along? _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	Relationship to You
Blindness	❑	❑	_____
Crossed eyes	❑	❑	_____
Glaucoma	❑	❑	_____
Cataracts	❑	❑	_____
Macular degeneration	❑	❑	_____
Retinal detachment	❑	❑	_____
Retinal disease	❑	❑	_____
Arthritis	❑	❑	_____
Cancer	❑	❑	_____
Diabetes	❑	❑	_____
Heart disease	❑	❑	_____
Stroke	❑	❑	_____
High blood pressure	❑	❑	_____
Lupus	❑	❑	_____
Thyroid disease	❑	❑	_____
Asthma	❑	❑	_____
Emphysema	❑	❑	_____
Epilepsy	❑	❑	_____
Allergies	❑	❑	_____
Migraine headaches	❑	❑	_____
Other: _____	❑	❑	_____

MEDICATIONS

Please note any medications you are currently taking and the reason for use. Include any pills, creams, drops, oral contraceptives, OTC.

Medication	Reason for Use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY *(This information is kept strictly confidential.)*

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long: _____

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long: _____

Do you use illegal drugs? ❑ Yes ❑ No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

REVIEW OF SYSTEMS **Place a check mark in the box to indicate any condition applicable to you.**
If you are filling out this form for someone else, please indicate any conditions applicable to them.

System	No	Yes
CONSTITUTIONAL		
Fever	❑	❑
Recent weight loss/gain	❑	❑
SKIN		
Rash/Itching	❑	❑
New moles/growths	❑	❑
Eczema	❑	❑
NEUROLOGICAL		
Headaches	❑	❑
Migraines	❑	❑
Dizziness/Lightheadedness	❑	❑
Seizures	❑	❑
Numbness/Tingling sensation	❑	❑
EYES		
Loss of Vision	❑	❑
Blurred Distance Vision	❑	❑
Blurred Near Vision	❑	❑
Distorted Vision/Halos	❑	❑
Loss of Side Vision	❑	❑
Double Vision	❑	❑
Night Vision problems	❑	❑
Color Vision problems	❑	❑
Dryness	❑	❑
Mucous discharge	❑	❑
Redness	❑	❑
Sandy or Gritty feeling	❑	❑
Itching	❑	❑
Burning	❑	❑
Excess tearing/watering	❑	❑
Glare/light sensitivity	❑	❑
Eye pain or soreness	❑	❑
Chronic infection of the eye or lid	❑	❑
Styes or Chalazion	❑	❑
Flashes/Floaters in Vision	❑	❑
Tired eyes	❑	❑
ENDOCRINE		
Thyroid problems	❑	❑
DiabetesType ____	❑	❑
Other gland problems	❑	❑

System	No	Yes
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	❑	❑
Sinus congestion	❑	❑
Runny Nose	❑	❑
Post Nasal Drip	❑	❑
Chronic cough	❑	❑
Dry throat/Mouth	❑	❑
RESPIRATORY	❑	❑
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
VASCULAR/CARDIOVASCULAR	❑	❑
Heart/Chest pain	❑	❑
High blood pressure	❑	❑
Vascular disease	❑	❑
GASTROINTESTINAL		
Diarrhea	❑	❑
Constipation	❑	❑
GENITOURINARY		
Kidney stones	❑	❑
Difficult/painful urination	❑	❑
Incontinence	❑	❑
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	❑	❑
Muscle pain/weakness	❑	❑
Joint pain/weakness	❑	❑
LYMPHATIC / HEMATOLOGIC		
Anemia	❑	❑
Bleeding/bruising problems	❑	❑
IMMUNOLOGIC		
HIV/AIDS	❑	❑
Sjogrens	❑	❑
PSYCHIATRIC		
Memory loss/Confusion	❑	❑
Nervousness/panic attacks	❑	❑
Insomnia	❑	❑
Depression	❑	❑

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair? _____

Are you planning to purchase glasses today? _____

Do you wear contact lenses? ❑ No ❑ Yes If yes, how old is your present pair?_____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended wear (sleep in lenses) ❑ Other Are they comfortable? ❑ Yes ❑ No

Are you interested in more information about Lasik surgery? _____

Are there any other concerns you would like to share with us today?

_____