Welcome Form

EYECARE ASSOCIATES
OF LEE'S SUMMIT

Name: _____

Date: _____ DOB: _____

Address: _____

SSN #: _____ Sex: *Male / Female* ***Email:***_____

Primary phone #: _____ Type (circle one): *Cell Home Work*

Secondary phone #: _____ Type (circle one): *Cell Home Work*

Circle the best way for us to contact you: *Email Cell# Work# Home # US Mail*

Emergency contact number & name: _____

Primary Language (circle one): *English Spanish Other:* _____

How did you hear about us (circle one)?

Friend/Family Internet search Insurance list Other: _____

Occupation: _____ Employer: _____

(Or for students) School: _____ Grade level: _____

Do you use the Computer more 4 or more hours per day? ***Yes* or *No***

Medical Doctor:_____ Last Physical:_____

Last Eye Doctor:_____ Last Exam:_____

Do you use Tobacco products? *Current User Former User Never used*

Do you drink Alcohol? *Never Socially Weekends Daily Specify:*

How old are your current glasses: _____ Updating today? ***Yes*** ***No*** ***Unsure***

If you wear **Contact Lenses**, circle the type: *Soft Rigid Sleep in lenses Scleral*

-Are they comfortable? ***Yes* or *No***

Ocular Health - Circle or List Any Eye Conditions You May Have:

Stye/Lid Bumps Dry Eye Floaters Glaucoma Cataracts Retinal Disease
Specify Others:

Please note any **Family History** of the following: (siblings, parents, grandparents, children)

Condition	Relationship	Condition	Relationship	Condition	Relationship
Blindness		Glaucoma		Macular Degeneration	
Diabetes		Allergies		Retinal Detachment	
Arthritis		Cross Eyes		Migraine Headaches	

Name: _____

List any Eye or Head Injuries, Surgeries or Hospitalizations:

_____

Medical history: List any conditions that you have been Diagnosed with by other doctors like Diabetes, High Cholesterol or Arthritis:

- If Diabetic: Type 1 or Type 2 Currently Using Insulin? ***Yes*** **or** ***No*** Last A1C? _____

_____

_____

_____

Please list any **Medications, Vitamins, or Supplements** you are taking, INCLUDING over the counter (pills, creams, drops, sprays, etc) and **Reason** for taking it: (Check if no medications: ☐)

_____

_____

_____

Please list any **Allergies** you have, including Medications: (Check if no known allergies: ☐)

_____

Please Circle any of the **Symptoms** below which you are **currently experiencing**:

Constitution:	Fever Over 10lb of weight change in last year: loss or gain	Muscles, Bones:	Muscle Pain or Weakness Joint Pain or Weakness
		Neurological:	Headaches
Cardiovascular:	Heart or chest pain High blood pressure		Migraines Dizziness/Lightheaded Seizures
Ears, Nose, Mouth, Throat:	Runny nose Allergies/Hay Fever Sinus Congestion Dry Throat or Mouth		Numbness/Tingling sensation
		Psychiatric:	Memory Loss/Confusion Nervousness/ Panic Attacks Insomnia
Respitatory:	Shortness of Breath Asthma		Depression
		Endocrine:	Thyroid Issues
Gastrointestinal:	Diarrhea Constipation		Hormone Changes
		Lymphatic, Hematologic:	Anemia Bleeding bruising Problems
Genitiurinary:	Kidney Stones Difficult urination Incontinence	Immunologic:	Graft vs Host Disease Sjorgen's Syndrome
Skin:	Rash/Itching New Growths or Moles Eczema	Other symptoms not listed above:	_____