Huntersville EYE CARE CENTER
Keith B. Miller, O.D.
Sonnie Bryant, O.D.

WE ARE GLAD YOU ARE HERE!
TO ENSURE THE BEST SERVICE POSSIBLE,
PLEASE ANSWER THE FOLLOWING
QUESTIONS.

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TODAY'S DATE: _____
NAME: _____PREFERRED:_____ DATE OF BIRTH: _____ SEX: M☐ F☐
STREET ADDRESS:_____CITY:_____STATE:_____ZIP_____
E-MAIL: _____ SS#: _____
HOME PHONE: _____ CELL: _____SPOUSE'S NAME:_____
NAME/LOCATION OF PRIMARY PHYSICIAN: _____
VISION INSURANCE: _____ MEDICAL INSURANCE(S): _____PRIMARY_____
RACE: _____ PREFERRED LANGUAGE: _____

PLEASE FILL IN THIS PORTION ONLY IF THE PATIENT IS UNDER 18 YEARS OLD:

Mother's Name: _____
Mother's Employer _____ *Work phone* _____
Mother's DOB _____/_____/_____ *SS#* _____-_____- _____ *Insurance Company:* _____
Mother's address if different: _____

Father's Name: _____
Father's Employer _____ *Work phone* _____
Father's DOB _____/_____/_____ *SS#* _____-_____- _____ *Insurance Company:* _____
Father's address if different: _____

In the event of an emergency , contact: _____
Relationship: _____ *Phone* _____

IF YOU ARE NEW TO OUR OFFICE, HOW DID YOU HEAR ABOUT US?

☐ Another Doctor_____ ☐ Saw Building/Sign ☐ Website
☐ Insurance Listing ☐ Magazine ☐ Friend/Family member_____
☐ Yellow Pages ☐ Newspaper ☐ Other _____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS? Please check all that apply.

☐ Stroke/Vascular Disease ☐ Cancer ☐ Skin eczema/Rash
☐ Diabetes ☐ Seizures ☐ Thyroid Disease
☐ High Blood Pressure ☐ Lung Disease/Asthma ☐ Arthritis
☐ High Cholesterol ☐ Headaches/ Migraines ☐ Weight loss/Gain
☐ Heart Disease ☐ Pregnant/Breast Feeding ☐ Autoimmune_____
☐ Kidney/Bladder ☐ Psychiatric ☐ Other_____

CURRENT MEDICATIONS? NONE ☐ YES ☐ PLEASE LIST: (INCLUDE OVER THE COUNTER, HERBS, VITAMINS AND BIRTH CONTROL)_____

DRUG ALLERGIES? NONE ☐ YES ☐ PLEASE LIST: _____

DO YOU USE: TOBACCO PRODUCTS? YES ☐ NO ☐ ALCOHOL? YES ☐ NO ☐ RECREATIONAL DRUGS? YES ☐ NO ☐
IF YES, WHAT TYPE? FREQUENCY? HOW LONG? _____

PLEASE FILL OUT BACK ALSO.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING EYE CONDITIONS? Please check all that apply.

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Blindness
- ☐ Turned/Crossed Eyes
- ☐ Dry Eyes/Allergies
- ☐ Lazy Eye
- ☐ Retinal Detachment
- ☐ Eye Surgery
- ☐ Eye Injury
- ☐ Other _____

DO YOU HAVE A FAMILY HISTORY (parents, grandparents, brothers/sisters or children) OF ANY OF THE FOLLOWING DISEASES? Please check all that apply.

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment/Disease
- ☐ Blindness
- ☐ Turned/Crossed Eyes
- ☐ Lazy Eye

WHAT ARE THE REASONS FOR TODAY'S APPOINTMENT? Please check all that apply.

- ☐ Sudden Loss of Vision
- ☐ Distance Blurred Vision
- ☐ Near Blurred Vision
- ☐ Frequent Headaches
- ☐ Frequent Eyestrain
- ☐ Double Vision
- ☐ Eye turning in/out
- ☐ Watering/Tearing Eyes
- ☐ Red Eyes
- ☐ Eyes Itching/Allergies
- ☐ Eye Pain
- ☐ Burning/Dry Eyes
- ☐ Seeing Flashes of Light
- ☐ Contact Lens Discomfort
- ☐ Floating Spots in Vision
- ☐ Discharge from Eyes
- ☐ Matted Eyelids
- ☐ Unusual Light Sensitivity
- ☐ Foreign Matter in Eyes
- ☐ Other_____
- ☐ Annual/Routine Exam

LIFESTYLE QUESTIONS?

Who is your employer? _____
What is your occupation? _____
Do you have trouble with your current glasses? _____
Do you prefer not to wear your glasses at times?_____
Do you have more than one pair of prescription glasses?_____
Do you think you might benefit from thinner/lighter lenses?_____
Are your eyes sensitive to sunlight or bright lights?_____
Do you have prescription sunglasses?_____
Do you spend time or work outside?_____Doing what?_____
Do your eyes tire quickly while reading?_____
Do you use a computer?_____How much?_____
Do you have trouble with night time driving? (Glare)_____
Are you interested in Laser Vision Correction?_____
Do you have other family members in need of eyecare?_____
Are you involved in activities that may put your eyes in danger?_____If so, what?_____

CONTACT LENS QUESTIONNAIRE: (Please check all that apply)

- ☐ I am not interested in contact lenses.
- ☐ I have never worn contacts, but I am interested in my options
- ☐ I am not satisfied with the vision of my current contact lenses
- ☐ I am not satisfied with the comfort of my current contact lenses
- ☐ I currently wear contacts

If you wear contacts, What type? _____ What solutions? _____
Do you sleep in your lenses? Y☐ N☐ How often?_____
Replacement Schedule? ☐Daily ☐Two-Weeks ☐Monthly ☐Quarterly ☐Yearl

THANK YOU!