WELCOME TO SULLIVAN FAMILY EYE CARE

Thank you for choosing our practice for your eye care needs. Your answers on this form will help us better understand your vision and medical concerns. If you have any questions, do not hesitate to ask for assistance.

Name: ______________________________ Male Female
Last First M.I.

Preferred Name: ______________________________

Street Address: ______________________________

____
City State Zip

Birthdate: ____________ SS#: ____________ Marital Status: ____________

Spouse Name: ______________________________ Spouse Contact #: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______

Cell Phone: ____________ E-mail: ____________

Prefer to be contacted thru: Home Work Cell

Previous eye doctor: ____________ Family doctor: ____________

Have you ever been diagnosed with any of the following eye conditions?

Cataracts ______ Glaucoma ______ Dry Eye ______ Allergy ______ Macular Degeneration ______ Diabetic Retinopathy ______

Detached Retina ______ Iritis ______ Corneal Abnormality ______ Pupil Abnormality ______

Any previous eye injuries? ______________________________

Any previous eye surgeries? ______________________________

Any immediate family members that have the following?

glaucoma Yes ❒ No ❒ If yes, who? ______________________________

cataracts Yes ❒ No ❒ If yes, who? ______________________________

macular degeneration Yes ❒ No ❒ If yes, who? ______________________________

eye surgery Yes ❒ No ❒ If yes, who? ______________________________

hypertension Yes ❒ No ❒ If yes, who? ______________________________

diabetes Yes ❒ No ❒ If yes, who? ______________________________

Have you worn contact lenses in the past? ______________________________

Are you interested in contact lens options? ______________________________

Interests / Hobbies: ______________________________

Responsible party for this account: ______________________________

How did you find out about us? ______________________________

Occupation / grade: ______________________________

Employer / School Name: ______________________________

Employer Address: ______________________________

City: ____________ State: ____________ Zip: ____________

Emergency contact person and phone #: ______________________________

List all current medications, including over-the-counter:

Name	Reason

Pregnant or Nursing? ______

REVIEW OF SYSTEMS

ALLERGIC / IMMUNOLOGIC

❒ Drug Allergy list: ______

❒ Environmental Allergy: ______

❒ Rheumatoid arthritis
❒ Lupus
❒ Other ______

EYES

❒ Glaucoma
❒ Cataract
❒ Macular Degeneration
❒ Surgery
❒ Inflammatory Disorders
❒ Blurred Vision
❒ Double Vision
❒ Other ______

MUSCULOSKELOTAL

❒ Fibromyalgia
❒ Muscular Dystrophy
❒ Osteoarthritis
❒ Ankylosing Spondylitis
❒ Other ______

CARDIOVASCULAR

❒ Heart Disease
❒ Hypertension
❒ Stroke
❒ Vascular Disease
❒ Other ______

GASTROINTESTINAL

❒ Crohn's
❒ Colitis
❒ Ulcer
❒ Digestive Problems
❒ Other ______

NEUROLOGICAL

❒ Multiple Sclerosis
❒ Epilepsy
❒ Alzheimer's'
❒ Parkinson's
❒ Cerebrovascular
❒ Other ______

CONSTITUTIONAL

❒ Developmental Disability
❒ Weight Loss / Gain
❒ Fever
❒ Fatigue / Weakness
❒ Trauma
❒ Other ______

GENITOURINARY

❒ STD / Herpetic Viral / Chlamydia
❒ Other ______

PSYCHIATRIC

❒ Depression
❒ Panic Disorder
❒ Schizophrenia
❒ Other ______

EARS, NOSE, MOUTH, THROAT

❒ Upper Respiratory Tract Infection
❒ Ear Ache
❒ Runny Nose
❒ Sore Throat
❒ Ringing Ears / Tinitis
❒ Other ______

HEMATOLOGIC / LYMPHATIC

❒ Anemia
❒ Large Volume Blood Loss
❒ Leukemia
❒ Other ______

RESPIRATORY

❒ Cigarette Smoker/ Tobacco User
❒ Asthma
❒ Bronchitis
❒ Emphysema
❒ Other ______

ENDOCRINE

❒ Non-Insulin Dependent Diabetic
❒ Insulin Dependent Diabetic
❒ Thyroid Dysfunction
❒ Hormonal Dysfunction
❒ Other ______

INTEGUMENTARY

❒ Eczema
❒ Rosacea
❒ Psoriasis
❒ Other ______