WELCOME

GREEN HILLS EYECARE

Name: _____ Birthdate: _____ Age: _____

Sex: ☐ M ☐ F

Address: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____ SSN: _____ Marital Status: _____

Language: _____ Ethnicity: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Reason for Visit: ☐ Yearly Exam ☐ Need Glasses/Contacts ☐ Medical Eye Problem ☐ Other

Are you currently having any of the following problems? Check all that apply:

☐ Cataracts	☐ Allergies	☐ Tearing	☐ Night Vision
☐ Macular Degeneration	☐ Flashes/Floaters	☐ Discharge	☐ Glare/Halos
☐ Glaucoma	☐ Iritis/Uveitis	☐ Blurred Vision	☐ Loss of Vision
☐ Diabetes	☐ Retina Defect	☐ Eye Strain	☐ Double Vision
☐ Diabetic Retinopathy	☐ Redness	☐ Eye Pain	Other: _____
☐ Dry Eyes	☐ Burning	☐ Light Sensitivity	
☐ Eye Infection	☐ Itching	☐ Headache	

Do you have or have you ever had any of the following medical problems? Check all that apply:

☐ AIDS/HIV	☐ Diabetes	☐ Kidney/Liver Disease	☐ Shingles
☐ Arthritis	☐ Drug Sensitivity	☐ Lazy/Turned Eye	☐ Skin Condition
☐ Asthma	☐ Emphysema	☐ Lupus/MS	☐ Stroke
☐ Bleeding Disorder	☐ Eye Surgery/Injury	☐ Migraines	☐ Thyroid
☐ Cancer	☐ Glaucoma	☐ Pacemaker	☐ Tuberculosis
☐ Cataracts	☐ Heart Condition	☐ Retina Disease	☐ Keratoconus
☐ Cholesterol	☐ Hepatitis	☐ Rheumatic Fever	Other: _____
☐ Chemical Addiction	☐ High Blood Pressure	☐ Sinus/Allergies	

Medications (or attach list): _____

Allergies: _____

Are you pregnant/nursing?: ☐ Yes ☐ No Tobacco Use?: ☐ Yes ☐ No Amt_____

Alcohol Use?: ☐ Yes ☐ No Amt_____

Family History: ☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Condition ☐ Cancer ☐ Cataracts ☐ Macular Degeneration ☐ Glaucoma

Physician: _____ Last Exam: _____ Last Eye Exam: _____

Employer: _____ Occupation: _____ Hobbies: _____

Do you wear glasses?: ☐ Yes ☐ No If yes, when do you wear them? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, what brand? _____

How did you hear about us? ☐ Family ☐ Friend ☐ Co-Worker ☐ Facebook ☐ Website Other: _____