

WELCOME



GREEN HILLS EYECARE

Name: _____ Preferred Name: _____ Birthdate: _____

Address: _____ Zip Code: _____

Mobile Phone: _____ Secondary Phone: _____

Email: _____ SSN: _____ Marital Status: _____

Language: _____ Ethnicity: _____ Sex: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Reason for Visit: _____ Yearly Eye Exam _____ Need Glasses/Contact Lenses _____ Medical Eye Problem _____ Other

Do you wear Glasses? YES NO If yes, when do you wear them? _____

Do you wear Contact Lenses? YES NO If yes, what brand? _____

Are you currently having any of the following eye problems? (Please circle/list here) _____

Headaches	Dry Eyes	Discharge	Eye Injury	Loss of vision
Light Sensitivity	Burning	Redness	Eye Pain	Blurred vision
Eyestrain	Watering/Tearing	Itching	Flashes	Glare
Motion Sickness	Scratchy/Gritty	Allergies	Floaters	Halos
Computer Discomfort	Sore/Irritated	Eye Infection	Double Vision	Styes

Eye Surgeries/Procedures: _____ Date: _____

Eye Drops:: _____

Do you have or have you ever had any of the following medical problems? _____

Cataracts	Retina Defect/Disease	Cancer	Hepatitis	Parkinson's
Diabetic Retinopathy	Concussion	Cholesterol	High Blood Pressure	Skin Condition
Glaucoma	Migraines	Chemical Addiction	Kidney/Liver Disease	Shingles
Iritis/Uveitis	AIDS/HIV	Diabetes	Lupus	Stroke
Keratoconus	Arthritis	Drug Sensitivity	Multiple Sclerosis	Thyroid Disease
Lazy/Turned Eye	Asthma	Emphysema	Pacemaker	Tuberculosis
Macular Degeneration	Bleeding Disorder	Heart Condition	Other: _____	

Medications (or attach list): _____

Allergies: _____

Are you pregnant/nursing? YES NO Tobacco Use? YES NO Alcohol Use? YES NO

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

Primary Physician: _____

Employer: _____ Occupation: _____ Hobbies: _____

How did you hear about us? Google/Yelp Social Media Website Family/Friend/Coworker: _____