Maine Family Eye Care

Patient Information

Date: _____ Name to which you prefer to be called: _____

Patient's Name: _____ Pronouns: □ He □ She □ They
LAST FIRST MIDDLE INITIAL

Address: _____
STREET CITY STATE ZIP

□ Male □ Female □ Decline to Say □ Single □ Married □ Separated □ Divorced □ _____

Birth Date: ____/____/_____ Age: _____ Social Security _____
*If under 18, additional parent/guardian form required *Required for filing insurance

Cell Phone # _____Text □Y □N Other # _____ Ethnicity/Race: _____

Email Address: _____

Occupation/Grade: _____ Employer/School: _____

*Who is the primary on the insurance? □ I am □ _____
Name DOB SSN

PARENT/GUARDIAN INFORMATION

REQUIRED FOR MINORS

Name: _____ Relationship: _____ Phone # _____
*If different from above

Address: _____
*If different from above

HEALTH INFORMATION

Reason for Today's Visit: □ Medical Exam □ Routine Exam □ Other: _____

□ Annual Exam
□ Diabetic Exam
□ Glaucoma Exam
□ Physician Directed Exam
□ Injury
□ New Floaters
□ New/Worsening Headaches
□ Dry Eye Problems
□ Vision Changes
□ Difficultly Reading
□ Broke or lost glasses
□ Need new glasses
□ Need more contacts
□ Want to try contacts*
*NEVER worn before

Who is your Primary Care Doctor (PCP) Name/Practice _____

SOCIAL HISTORY

Tobacco Use:
□ None □ Former
□ Vape User □ Current Smoker

Alcohol Use:
□ None □ Social
□ Daily □ Recovery

Narcotic Use: Type: _____
□ None □ Recreational
□ Medicinal for Recovery □ Dependency

PATIENT OCULAR HISTORY

YES	NO	
☐	☐	Do you wear eye correction? ☐ Glasses ☐ Non-Rx Readers ☐ Contacts
☐	☐	Surgery or Laser to Eye(s) ☐ R ☐ L ☐ Both Sx Type:_____
☐	☐	Trauma/Injury to Eye(s) ☐ R ☐ L ☐ Both Injury Type:_____
☐	☐	Glaucoma
☐	☐	Macular Degeneration ☐ Dry ☐ Wet ☐Injections taken?
☐	☐	Crossed/Lazy Eye ☐ R ☐ L
☐	☐	Previous Retinal Detachment ☐ R ☐ L
☐	☐	Cataracts
☐	☐	Floaters ☐ New/Worsening Floaters
☐	☐	Flashes
☐	☐	Eye Fatigue
☐	☐	Glare / Haloes
☐	☐	Double Vision
☐	☐	Dry Eye
☐	☐	Tearing
☐	☐	Light Sensitivity
☐	☐	Itchy/Burning
☐	☐	Redness
☐	☐	Foreign Body/Gritty/Sandy Sensation

Last Eye Exam (Year/Date): _____

YES	NO	**FEMALES ONLY**
☐	☐	Pregnant or could be
☐	☐	Nursing

PATIENT MEDICAL HISTORY

YES	NO	
☐	☐	Diabetes ☐ PRE-Diabetic (not medicated) ☐ Type 1 ☐ Type 2 A1C _____ Year Diagnosed _____
☐	☐	Cardiovascular Problems ☐ Heart Attack ☐ Palpitations ☐ Vascular Dx
☐	☐	Hypertension (High blood pressure)
☐	☐	Cholesterol
☐	☐	Thyroid ☐ Hyper ☐ Hypo
☐	☐	Cancer Type: _____
☐	☐	Hearing Loss
☐	☐	Asthma ☐ COPD ☐ Emphysema
☐	☐	Sleep Apnea
☐	☐	Kidney Problems
☐	☐	IBD/IBS ☐ Crohn's
☐	☐	Acid Reflux Disease (GERD)
☐	☐	Rosacea
☐	☐	Psoriasis
☐	☐	Headaches ☐ Migraines ☐ w/Aura
☐	☐	Multiple Sclerosis
☐	☐	Seizures
☐	☐	ADHD
☐	☐	Alzheimer's/Dementia
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Arthritis ☐ Rheumatoid Arthritis
☐	☐	Muscle Pain ☐ Joint Pain
☐	☐	Anemia
☐	☐	Lupus

Other Medical Hx: _____

MEDICATIONS: ☐ None ☐ Yes: _____

_____

_____

DRUG ALLERGIES: ☐ None ☐ Yes: _____

EYE MEDICATIONS/OTC DROPS: ☐ None ☐ Yes: _____

☐ Systane ☐ Blink ☐ Refresh ☐ Lumify ☐ Pataday ☐ Visine

FAMILY HISTORY

Please check off each item as it pertains to your parents, grandparents, siblings, children (living or deceased)

	If yes, state relation		**If yes, state relation**
Glaucoma	☐ Yes _____	Diabetes	☐ Yes _____
Macular Degeneration	☐ Yes _____	Hypertension	☐ Yes _____
Crossed / Lazy Eye	☐ Yes _____	Cardiovascular	☐ Yes _____
Retinitis Pigmentosa	☐ Yes _____	Thyroid Disease	☐ Yes _____
Retinal Detachment	☐ Yes _____	Cancer (type)	☐ Yes _____
Sjögren's Syndrome	☐ Yes _____		☐ **Unknown History/Adopted**

Other Family Hx (List Issue/Relation) ☐ Yes _____