Welcome To Our Office

Sager Eye Care Center

In order to provide you with the best possible eye care, please answer the following questions:

PATIENT INFORMATION

Today's Date: _____

Last _____

First _____MI _____

Date of Birth _____Age _____

Gender _____ Marital Status S M W D

Patient's SSN_____

Address _____Apt #____

City _____ State ____ Zip Code_____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Occupation _____

Employer_____ FT___ PT____

If Student:

School _____ Grade _____

Spouse (or parent/guardian) Name _____

What is the main purpose of this visit? _____

FAMILY HISTORY

DISEASE/CONDITION			RELATIONSHIP
Blindness	Y	N	_____
Cataract (Surgery)	Y	N	_____
Corneal Problems	Y	N	_____
Crossed Eyes/ Lazy Eyes	Y	N	_____
Glaucoma	Y	N	_____
Macular Degeneration	Y	N	_____
Retinal Detachment/ Disease	Y	N	_____
Arthritis	Y	N	_____
Cancer	Y	N	_____
Diabetes	Y	N	_____
Heart Disease	Y	N	_____
High Blood Pressure	Y	N	_____
Kidney Disease	Y	N	_____
Lupus	Y	N	_____
Thyroid Disease	Y	N	_____
Other	Y	N	_____

INSURANCE INFORMATION

VISION INSURANCE _____

Subscriber Name _____

Subscriber SSN _____

Subscriber DOB _____

Group # _____ Plan ID _____

PRIMARY MEDICAL INSURANCE_____

Subscriber Name _____

Subscriber SSN _____

Subscriber DOB _____

Group # _____ Plan ID _____

SECONDARY MEDICAL INSURANCE_____

Subscriber Name _____

Subscriber SSN _____

Subscriber DOB _____

Group # _____ Plan ID _____

◇ Please be aware that during the exam if a medical diagnosis is found, we may need to use your medical insurance due to the fact that your vision insurance will not cover some services.

Method of Payment *Cash Check Credit Card*

VERY IMPORTANT! NEW PATIENTS ONLY

Who may we thank for referring you to our office?

_____

If you were not referred, how did you select our office?

- ◯ Another Doctor
- ◯ Internet Search
- ◯ Signage/Location
- ◯ Print Media
- ◯ Insurance List
- ◯ Other

_____

LIFESTYLE - DO YOU..... (check all that apply)

- ◯ Work at a computer?
- ◯ Prefer to not wear your glasses at times?
- ◯ Have interest in CONTACT LENSES? ____Clear ____ Colored
- ◯ Want information on vision correction surgery/laser vision/ Lasik Correction ?
- ◯ Spend time outdoors?
- ◯ Have prescription sunglasses?
- ◯ Have interest in updating your eyeglass frames?
- ◯ Think you might benefit from thiner, lighter lenses?

Hobbies/Recreational Sports _____

_____

_____

EYE HEALTH HISTORY

The information in this confidential case history form is critical to the evaluation of your vision and health.

Date of your last eye exam _____
By Whom? _____

Do you wear eyeglasses? Yes No
Are you having problems with your current glasses? Yes No
Have you ever tried contact lenses? Yes No
Do you currently wear contact lenses? Yes No
What kind? _____
Solution Used _____
Are you interested in contact lenses to change the color of your eyes?
_____
If you wear contact lenses, are you satisfied with the vision and comfort? Yes No
Do you have a backup pair of eyeglasses? Yes No

Do you ever experience or have you ever experienced:

- ◯ Blurry vision
- ◯ Redness
- ◯ Ocular discharge
- ◯ Eye pain/soreness
- ◯ Chronic Infection of the eye or eyelid
- ◯ Sties or Chalazion
- ◯ Dryness
- ◯ Burning
- ◯ Tearing/watering
- ◯ Itchiness
- ◯ Grittiness
- ◯ Foreign body sensation
- ◯ Distorted Vision
- ◯ Loss of any vision
- ◯ Flash of light
- ◯ Floaters/Spots
- ◯ Trouble seeing at night
- ◯ Glare/light sensitivity
- ◯ Halos around lights or starbursts
- ◯ Tired eyes
- ◯ Excessive blinking
- ◯ Neck/shoulder pain at computer
- ◯ Headaches
- ◯ Dizziness
- ◯ Double Vision
- ◯ Crossed eyes/eye turn

Have you ever been diagnosed or treated for the following:

- ◯ Glaucoma
- ◯ Corneal Abrasion
- ◯ Eye Infection
- ◯ Eye Injury
- ◯ Cataracts
- ◯ Iritis / Uveitis
- ◯ Lazy Eye
- ◯ Macular Degeneration
- ◯ Retinal Detachment
- ◯ Other eye disorders

Date of Cataract Surgery _____Right _____ Left
By Whom _____

SOCIAL HISTORY

The following information is kept strictly confidential. However you may discuss this information directly with your doctor if you prefer.

◯ *Yes, I would prefer to discuss my social history information directly with my doctor (check box)*

Weight _____ Height _____

Do you use tobacco products? Yes No
If yes, type/amount/how long? _____
Do you drink alcohol? Yes No
If yes, type/amount/how long? _____
Do you use illegal drugs? Yes No
If yes, type/amount/how long? _____
Have you ever been exposed to or infected with:

- ◯ Gonorrhea
- ◯ HIV
- ◯ Hepatitis
- ◯ Syphilis

MEDICAL HISTORY

Name of Medical Doctor _____
Address _____
Phone _____
Date of last physical exam _____
Do you have any allergies including to medication? **Yes** **No**
If yes, please explain _____
_____
List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies)
_____
_____
Are you currently pregnant or nursing? **Yes** **No**
List all major injuries, surgeries and/or hospitalizations you have had _____
_____
_____
_____

Do you currently, or have you ever had any problems in the following areas?

Constitutional		
Fever, Weight Loss/Gain	**Y**	**N**
Integumentary (Skin)	**Y**	**N**
Neurological		
Headaches/Migraines	**Y**	**N**
Stroke	**Y**	**N**
Seizures	**Y**	**N**
Endocrine		
Thyroid/Other Glands	**Y**	**N**
Ears, Nose, Mouth, Throat		
Allergies/Sinus	**Y**	**N**
Chronic Cough	**Y**	**N**
Dry Throat/Mouth	**Y**	**N**
Respiratory		
Asthma	**Y**	**N**
Chronic Bronchitis	**Y**	**N**
Vascular		
Diabetes	**Y**	**N**
Heart Pain	**Y**	**N**
High Blood Pressure	**Y**	**N**
Vascular Disease	**Y**	**N**
High Cholesterol	**Y**	**N**
Gastrointestinal		
Crohn's Disease	**Y**	**N**
Acid Reflux/IBS	**Y**	**N**
Genitourinary		
Genitals/Kidney/Bladder	**Y**	**N**
Bones/Joints/Muscles		
Rheumatoid Arthritis	**Y**	**N**
Muscle Pain	**Y**	**N**
Joint Pain	**Y**	**N**
Lymphatic/Hematologic		
Anemia	**Y**	**N**
Bleeding Problems	**Y**	**N**
Allergic/Immunologic	**Y**	**N**

If you answered **YES** to any of the above, or have a condition not listed, please explain:
_____
_____
_____

Patient Name: