Welcome to Bussey Eyecare Center!

Name: _____ Date of Birth:_____

Social Security #_____

Cell phone: (____)_____Work phone: (____)_____ I prefer you: (call) or (text) me

How should we remind you about appointments? O text O email O phone call

How should we let you know your orders are in? O text O email O phone call

Address: _____

Email: _____

Gender: O Female O Male Ethnicity: O Hispanic or Latino O Not Hispanic or Latino

Race: O American Indian O Asian O African O Native Hawaiian O White

Employer:_____

Person responsible for account:_____

Emergency Contact:_____Phone#:_____

Lifestyle History

Do you have sunglasses? O Yes-prescription O Yes-drugstore O No

Do you wear contacts? O Yes-everyday O Yes-occasionally O No-I did in the past O No-never

Brand of Contacts:_____

What hobbies and interests do you participate in? _____

What do you NOT like about your current glasses?_____

_____

Reason for Visit

O Annual eye exam O Diabetic Eye Exam O Need contact lenses O Need glasses O Medical concerns

Are there any concerns with the health of your eyes or vision?_____

_____

Medical and Eye History

Do you experience any:	Have you had in your eyes:	Do you have:	Is there a family history of:
O Dry or scratchy eyes	O Amblyopia lazy eye	O Diabetes, Last A1C:__	O Glaucoma
O Tired or strained eyes	O Glaucoma	O High blood pressure	O Macular Degen.
O Flashes of light	O MacularDegeneration	O Arthritis	O Cataract
O Poor night vision	O Cataracts	O Lupus	O Retinal Detachment
O Redness of eyes	O Retinal Detachment	O Anemia	O Keratoconus
O Glare \light sensitivity	O Color Blindness	O Thyroid Dysfunction	O Blindness
O Excessive watering	O Eye Injury	O Heart conditions	O Diabetic Vision Loss
O Headaches	O Infection	O Respiratory	
O Blurred vision	O Corneal Ulcers	OSkin condition	

O Double vision	O Keratoconus	O Migraines	Do you use:
O Loss of vision	O Strabismus	O Neuro (Seizure, MS..)	O Tobacco products
Other:	O Eye surgery	O Mental Health Disord.	O Used to use tobacco
		O Blood/Lymph disorder	OAlcohol
		O Cancer	O Recreational Drugs
		O Explain:	

Please list all **medications** you are taking (including vitamins):

_____

_____

_____

Please list any **allergies to any medications:**

_____

_____

Are you currently pregnant or nursing? O Yes O No

Are you under the care of an ophthalmologist (eye surgeon) O Yes O No If yes, who?

Who is your primary care physician?_____

Acknowledgement of Receipt of Privacy Practice

I acknowledge that I received (or have access to) a copy of Bussey Eyecare Center's Notice of Privacy Practices.

Patient (or guardian) signature:_____

I hereby give the following person rights to my medical records:_____