PrecisionEyeGroup

Dr. Brandy Deckard Dr. Derek Bailey

Patient Information Record

Patient's Last Name ______________________ First Name ______________________ MI ________

Address ______________________ City ______________ State _____ Zip ________

Home Phone ______________________ Work Phone ______________________

Cell Phone ______________________ E-mail ______________________

How do you prefer we contact you?

☐ Work Phone ☐ Cell ☐ E-mail ☐ Any of the Options

Social Security No. ______________ Birth Date ______________ Sex ☐M ☐F Age ________

Occupation & Employer ____

(if student, list grade, school name)

Marital Status ______________________

Name of Spouse or Nearest Living Relative ______________________ Relationship ______________

Phone Number ______________________ Address (if different than above) ______________________

Date of last eye exam ______________________

Do you wear...? ☐ Glasses ☐ Contact Lenses

Are you interested in...?

☐ Glasses ☐ Contact Lenses ☐ Vision correction surgery ☐ Other ______________

How did you hear about our office? ☐ Referral Whom may we thank for the referral? ______________

☐ Google ☐ Instagram ☐ Local Advertising ☐ Phone Book ☐ Other

☐ Facebook ☐ Twitter ☐ Insurance Provider ☐ Yelp ______________

Who will be responsible for the financial aspects of this case? (please check all that apply)

☐ Patient ☐ Parent/Guardian ☐ Insurance ☐ Other ______________________

If patient is under the age of 18: Signature of parent or guardian authorizing treatment ______________

Name of insurance policy holder (if different from patient) ______________________

Date of birth of policy holder ______________________

Thank you for your cooperation. Please complete form on back of this page.

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Medical History Record

Name of Primary Care Physician ______________________ Specialty Physician ______________________

Allergies: List all known medical allergies and environmental allergies

____

Medications: Please list below (or provide a list of) all medications, including eye drops, non-prescription drugs, vitamins or herbal supplements. Please include dosages of all medications perscribed or over the counter.

____

____

Do you currently have any of the following problems?	Yes	No	If Yes, please explain:
Ear/Nose/Throat Problems (hearing loss, sinus problems, sore throat)	☐	☐	______________
Neurologic Problems (numbmess, weakness, headaches, paralysis)	☐	☐	______________
Psychiatric Problems (depression, anxiety)	☐	☐	______________
Cardiovascular Problems (heart disease, high blood pressure, heart arrhythmia)	☐	☐	______________
Respiratory (asthma, bronchitis, shortness of breath)	☐	☐	______________
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea)	☐	☐	______________
Urinary Problems (pain or discomfort, blood in urine)	☐	☐	______________
Musculoskeletal Problems (muscle aches, joint pain, arthritis)	☐	☐	______________
Skin Problems (rashes, excessive dryness, rosacea)	☐	☐	______________
Endocrine (diabetes, thyroid problems)	☐	☐	______________
Hematologic/Lymphatic (anemia, bleeding problems)	☐	☐	______________
Allergy/Immunologic (environmental allergies, immuno-compromising disease)	☐	☐	______________

Do you currently have any of these eye related symptoms?

	Yes	No
Blurred or Distorted Vision	☐	☐
Double Vision	☐	☐
Dry, Itchy, Red or Burning Eyes	☐	☐
Mucous Discharge	☐	☐
Sandy Gritty Feeling	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain/Soreness	☐	☐
Chronic Infection of Eye/lid	☐	☐
Stye/Chalazion	☐	☐
Flashes/Floaters in Vision	☐	☐

Have your immediate family members (parent, sibling, child) ever had any of the following conditions?

	None	Relationship
Cataract	☐	______________
Glaucoma	☐	______________
Eye Injury	☐	______________
Crossed/Lazy Eye	☐	______________
Retinal Detachment	☐	______________
Retinal Degeneration	☐	______________
Macular Degeneration	☐	______________
Blindness	☐	______________
Diabetes (type 1 or 2)	☐	______________
Hypertension	☐	______________
Hyperthyroidism	☐	______________
Hypothyroidism	☐	______________
Cancer	☐	______________

Surgeries: List any previous surgeries, including eye surgeries and laser procedures.

____

Height __________ Weight ______________ Are you pregnant/nursing? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Frequency ____________

Do you currently smoke? ☐ Yes ☐ No If Yes, how much __________ How long have you been smoking? __________

If No, have you previously been a smoker? ☐ Yes ☐ No

Patient or Guardian Signature ______________________________ Date ________________