

Welcome to Norton Eye Care

Date: ____/____/____

Patient Information

Salutation: Mr. Mrs. Ms. Dr.

Name: _____

Nickname: _____

Suffix: Jr. Sr. II III

Credentials: MD OD DO DDS PHD

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Preferred Communication: Phone Email

Date of Birth: ____/____/____ Social Security Number: ____-____-____

Gender: Male Female Marital Status: Single Married Other

Guardian: _____ Relationship: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

How did you hear about us?

Drive by/Signage Advertisement Facebook/Twitter/Instagram Google Yelp
 Insurance CareCredit Doctor Referral: _____ Friend or Family: _____

Primary Care Physician: _____

Previous Eye Doctor: _____ Last Eye Exam: ____/____/____

Employer: _____ Occupation: _____

Sports/Hobbies: _____

Drink: Yes No Smoke: Yes No

Major Injuries/Surgeries: _____

Medications: _____

Allergies: Drug: _____ Environmental Latex

Blood Pressure: ____/____

Personal Medical History

Constitutional

- Fever
- Weight loss/gain
- Fatigue
- Trauma
- Cancer
- Developmental Disabilities

Neurologic

- MS
- Epilepsy
- Cerebral Palsy
- Tumor
- Migraine

Cardiovascular

- High Blood Pressure
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea

Ear/Nose/Throat

- Hearing Loss
- Sinusitis
- Dry Mouth

Psychiatric

- Depression
- ADD/ADHA
- Anxiety
- Bipolar Disorder

Genitourinary

- Kidney Disease
- Prostate Disease
- STD
- Benign Prostate Hypertrophy

Integumentary

- Eczema
- Rosacea
- Psoriasis

Endocrine

- Type 2 Diabetes Mellitus
- Type 1 Diabetes Mellitus
- Herpes Simplex
- Thyroid Dysfunction
- Herpes Zoster/Shingles

Gastrointestinal

- Chrohn's
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease

Musculoskeletal

- Osteoarthritis
- Arthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis

Hematologic/Lymphatic

- Anemia
- Ulcer
- High Cholesterol

Autoimmune

- Hormonal Dysfunction
- Osteoporosis
- Rheumtaoid arthritis
- Gout
- Sjogren's
- Lupus

Ocular/Eye History

- Glaucoma
- Cataract
- Surgery
- Patching
- Inflammatory Disorder
- Nystagmus
- Strabismus
- Amblyopia
- Keratoconus
- Injury
- Dry Eye
- Retinal Degeneration/Hole/Detachment
- Age-Related Macular Degeneration
- Other: _____

I wear: Glasses Contact Lenses Contact Brand: _____

How long do you wear your contacts before you throw them away? _____

Do you sleep in your contacts? Yes No

Contact Lens Solution: Opti-Free BioTrue Clear Care Renu Generic

Other Eye Drops: _____

Family History

Medical

- High Blood Pressure
- Diabetes
- Cancer
- Thyroid
- Other: _____

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