McBride Vision Clinic

Patient Information Form

Patients First Name: _____Middle:_____Last:_____

Date of Birth: _____Drivers License Number_____Issuing State_____Expires_____

Address_____City_____State____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Email_____Patients Employer_____Occupation_____

Patients Social Security_____Primary Insured Social Security_____

Is this your 1st visit to our office (circle) Yes / No If yes, please tell us who referred you: _____

Please tell us the reason for your visit:

_____

Are you planning to get new glasses on this visit? (Circle) Yes / No
Do you wear contact lenses? (Circle) Yes / No

Race

- € American Indian Or Alaska Native
- € Asian
- € Black Or African American
- € Native Hawaiian Or Other Pacific Islander
- € White
- € Other
- € Not Disclosed

Ft in
Height_____/_____
Weight_____lbs

Ethnicity

€ Hispanic or Latino € Not Hispanic or Latino € Unknown

Insurance Information

Medical Insurance Company_____Id #_____Group#_____

Vision Insurance Company_____Id#_____Group#_____

Primary PhysiciansName: _____ClinicName_____

Address: _____Phone Number:

_____

Signature: _____Date:_____

Medication

Please List any Medications you are currently taking:

- o _____
- o _____
- o _____

Drug Allergies

Do you have any drug allergies (circle) Yes / No If yes, please list the medication(s) and any reaction(s) : _____

_____

Medical History

- ☐ Headaches
- ☐ Eye Infection
- ☐ Drooping Eyelid
- ☐ Crossed Eyes
- ☐ Floaters or Spots
- ☐ Loss of Side Vision
- ☐ Macular Degeneration
- ☐ Color Blindness
- ☐ Amblyopia(lazy eye)
- ☐ Double Vision
- ☐ Cataract(s)
- ☐ GlareLight Sensitivity
- ☐ Excess Tearing/Watering
- ☐ Sandy or Gritty Feeling
- ☐ Blurred Vision Distance
- ☐ Distorted Vision (halos)
- ☐ Foreign Body Sensation
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Eye Pain or Soreness
- ☐ Blurred Vision Near
- ☐ Other
- ☐ Tired Eyes
- ☐ Redness
- ☐ Itching
- ☐ Dryness
- ☐ Burning
- ☐ Loss of Vision
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Fluctuating Vision
- ☐ Mucous Discharge

General Health Condition

- ☐ Kidney
- ☐ Ears, Nose, Throat
- ☐ Neurological
- ☐ Joint Pain
- ☐ Bleeding Problems
- ☐ Diabetes
- ☐ Pregnant or Nursing
- ☐ Smoke Cigarettes
- Consume Alcohol
- ☐ High Blood Pressure
- ☐ Dry Throat/ Mouth
- ☐ Rheumatoid Arthritis
- ☐ Gastrointestinal
- ☐ Fever
- ☐ Allergic
- ☐ Skin
- ☐ Endocrine
- ☐ Anemia
- ☐ Genitals/Kidney/Bladder
- ☐ Sinus Congestion
- ☐ Post-Nasal Drip
- Lupus
- ☐ Other System
- ☐ Chronic Bronchitis
- ☐ AIDS/HIV
- ☐ Weight Loss
- ☐ Muscles, Bones, Joints
- ☐ Respiratory (Asthma)
- ☐ Psychiatric
- ☐ Cardiovascular Disease
- ☐ Heart Disease
- ☐ Cancer
- ☐ Runny Nose
- ☐ Chronic Cough
- Stroke
- ☐ Thyroid Disease
- ☐ Emphysema
- ☐ Blood/Lymph

Family History

- ☐ Stroke
- ☐ Amblyopia (Lazy Eye)
- ☐ Glaucoma
- ☐ High B.P.
- ☐ Color Blindness
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Lupus
- ☐ Diabetes
- ☐ Other
- ☐ Kidney Disease
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Crossed Eyes
- ☐ Cataract(s)
- ☐ Blindness
- ☐ Heart Disease

Signature_____ **Date:**_____