

McBride Vision Clinic

Patient Information Form

Patients First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Land Line _____ Cell _____ Work _____

Address City _____ State _____ Zip Code _____

Email _____ Patients Employer _____ Occupation _____

Last 4 # of Social Security: Patient _____ Primary Insured _____

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? Yes / No Do you wear contact lenses? Yes / No

Race

- 0) American Indian Or Alaska Native
- 0) Asian
- 0) Black Or African American
- 0) Native Hawaiian Or Other Pacific Islander

- 0) White
- 0) Other
- 0) Not Disclosed

Ft In
 Height _____ / _____
 Weight _____ lbs

Ethnicity

- 0) Hispanic or Latino
- 0) Not Hispanic or Latino
- 0) Unknown

Insurance Information

Medical Insurance Company _____ Id # _____ Group# _____

Vision Insurance Company _____ Id# _____ Group# _____

Primary Physicians Name: _____ Clinic Name _____

City: _____ Phone Number: _____

Medication

Please List any Medications you are currently taking:

- 1) _____ 2) _____
- 2) _____ 4) _____
- 5) _____ 6) _____

Drug Allergies

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

Current Eye Disease and Symptoms

Amblyopia	Y / N	Glare	Y / N	Blurred Vision	Y / N
Blepharitis	Y / N	Headaches	Y / N	Double Vision	Y / N
Cataracts	Y / N	Light Sensitivity	Y / N	Flashes of Light	Y / N
Color Blindness	Y / N	Tired Eyes	Y / N	Fluctuating Vision	Y / N
Diabetic Retinopathy	Y / N	Burning	Y / N	Loss of Central Vision	Y / N
Dry Eye Disease	Y / N	Dryness	Y / N	Loss of Side Vision	Y / N
Eye Injuries/ Surgeries	Y / N	Tearing	Y / N		
Glaucoma	Y / N	Eye Lid Swelling	Y / N		
High Risk Medication	Y / N	Eye Pain	Y / N		
Macular Degeneration	Y / N	Itching	Y / N		
Floater	Y / N	Redness	Y / N		
Retinal Detachment	Y / N	Sandy/ Gritty	Y / N		
Strabismus	Y / N				
Other					

Review of Systems

Constitutional Symptoms (fever, weight loss, etc.)	Y / N
Ear, Nose and Throat	Y / N
Cardiovascular (heart, hypertension, etc.)	Y / N
Respiratory (asthma, emphysema, etc.)	Y / N
Gastrointestinal	Y / N
Genital, Kidney, Bladder	Y / N
Muscles, Bones, Joints (arthritis, etc.)	Y / N
Skin (rash, itching, skin cancer, etc.)	Y / N
Neurological (multiple sclerosis, etc.)	Y / N
Psychiatric (anxiety, depression, etc.)	Y / N
Endocrine (diabetes, hypothyroid, etc.)	Y / N
Blood/Lymph (anemia, cholesterol, etc.)	Y / N
Allergic/ Immunologic (seasonal allergies, lupus, etc.)	Y / N
Pregnant	Y / N
Nursing	Y / N

Family History

Eye Disease

Amblyopia	Y / N
Blindness	Y / N
Cataracts	Y / N
Color Blindness	Y / N
Eye Tumors	Y / N
Glaucoma	Y / N
Macular Degeneration	Y / N
Retinal Detachment	Y / N
Strabismus	Y / N
Other Eye Conditions	Y / N

Systemic Disease

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
Stroke	Y / N
Thyroid Disease	Y / N

Signature: _____

Date: _____