Welcome to King Eye Center

Date:_____

Patient Information (Please Print)

Patient's name:

(Last)_____ (First)_____ (Middle)_____

Address (*street*) _____

City, State, ZIP _____ Primary Phone _____

Cell Phone_____ Text ok? *Yes* or *No* Email_____

Social Security Number _____

Marital Status: ☐ Single ☐ Married ☐ Other

Date of birth_____ Age_____Sex ☐ Male ☐ Female Student: *yes* or *no*

Employer_____ Occupation_____

Whom may we contact in the event of an emergency?_____Phone_____

Your primary care doctor (MD)_____

***What problem(s) or changes are you having with your eyes or vision today?**

_____

_____

Do you currently wear either of the following (please circle one)**?** Glasses Contacts

Please review our Notice of Privacy Practices (available at the front desk) and sign below…

I have reviewed the Notice of Privacy Practices of King Eye Center.

_____ (Signature)

_____ (Date)

Medical History

Are you ***allergic*** to any medications? ***Yes*** or ***No***

If **YES**, please list the medications: _____

Have you ever had or do you currently have any of the following?

Eyes	**Yes**	**No**
Cataracts	( )	( )
Eye Surgery (please indicate type)	( )	( )
Eye Injury (please indicate type)	( )	( )
Retinal Detachment	( )	( )
Glaucoma	( )	( )
Allergic/Immunologic		
Hay Fever/Sinus	( )	( )
Cancer (please indicate type)	( )	( )
Cardiovascular		
High Blood Pressure	( )	( )
High Cholesterol	( )	( )
Endocrine		
Diabetes	( )	( )
Thyroid Problems	( )	( )

Musculoskeletal	**Yes**	**No**
Arthritis	( )	( )
Muscle/Joint Pain	( )	( )
Neurological		
Headaches	( )	( )
Migraines	( )	( )
Seizures	( )	( )
MS	( )	( )
Psychiatric		
Nervous Disorders	( )	( )
Depression	( )	( )
Respiratory		
Shortness of Breath	( )	( )
Emphysema	( )	( )
Asthma	( )	( )
Lung Cancer	( )	( )

FAMILY

Do any of your family members have glaucoma, diabetes, retinal detachment, or macular degeneration? ***Yes*** or ***No***

If **YES**, please indicate specific family member and disease: _____

SOCIAL

(please circle one)

Do you drink alcohol?	☐ YES	☐ NO	If YES:	Socially	1-2/day	3+/day	Dependent
Do you smoke?	☐ YES	☐ NO	If YES:	Occasional	½ pack/day	1 pack/day	2+pack/day
						Former Smoker	

MEDICATIONS

Please list your current medications (or give a compiled list to receptionist so we can obtain a copy):

_____

_____

_____