# 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):

_____

_____

_____