# 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 Race: _________________________

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)______________________________

How did you hear about us? Internet/Social Media Family/Friend Doctor/Referral Other

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

______________________________________________________________________

______________________________________________________________________

**Do you currently wear either of the following** (circle any that apply)**?** 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):

______________________________

______________________________