

Why are you here today? _____

Did a doctor refer you? Yes ____ No ____ Name _____
 (please check one)

Do you wear glasses? Yes No
 (please check one)

Type of glasses? Single vision/reading Bifocal Trifocal Progressive
 (please check one)

Do you wear contact lenses? Yes No
 (please check one)

Type of contact lenses: Rigid Soft Yearly Disposable Other _____

Eyes: (please check all that apply)

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Stinging/Burning	<input type="checkbox"/> Excess watering/tearing
<input type="checkbox"/> Flashes/Floaters	<input type="checkbox"/> Red/Itchy	<input type="checkbox"/> Other, _____ (please explain)

Medications (including any eye drops and over the counter medications)

Medication	Dose	Reason for Medication	Side Effects

Previous Eye Dr. _____ Phone(____) ____ - ____ Last exam: ____
Name City/State

Primary Care Physician: _____ Phone(____) ____ - ____ Last exam: ____
Name City/State

Review of Symptoms:

Are you currently having or have you had any problems with your

	Circle	Describe all Yes responses
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	One	
Skin	Yes No	_____
Headaches, Migraines, Seizures	Yes No	_____
Thyroid	Yes No	_____
Ears, nose, throat, mouth	Yes No	_____
Respiratory	Yes No	_____
Diabetes	Yes No	_____
High Blood Pressure	Yes No	_____
Heart Pain	Yes No	_____
Gastrointestinal	Yes No	_____
Genito-Urinary	Yes No	_____
Rheumatoid Arthritis/Joint Pain	Yes No	_____
Bleeding Problems/Anemia	Yes No	_____
Allergic/ Immunologic	Yes No	_____
Psychological problems	Yes No	_____
Are you pregnant	Yes No	_____

or nursing?		
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Past Medical History

Surgeries/Hospitalizations Year Complications

Family History

Member	Any chronic illness or eye diseases? Ex. Hypertension, Diabetes, Cataracts, Glaucoma
Grandmother (mom's)	
Grandfather (mom's)	
Grandmother (dad's)	
Grandfather (dad's)	
Father	
Mom	
Sister/Brother	
Sister/Brother	

Sister/Brother	
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Are you allergic to any Medications? Yes No (please check one)

If yes, please list: _____

Social History

History of substance abuse? No Yes What? _____

Smoke currently? No Yes _____ Packs per day for _____ years

Drink alcohol? Daily 1-2 times a week 1-2 times a month 1-2 times a year Never

Have you been infected or exposed to any of the following: HIV/AIDS Hepatitis

HIPPA COMPLIANCY FORM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have reviewed the Bridgeport Eye Center's **Notice of Privacy Practices**, which explains how my medical information will be used and disclosed.

If you are not familiar with the Privacy Practices, a viewable copy is available at the front desk.

Patients Printed Name

Date of Birth

Signature of Patient or Legal Representative

Date

If Legal Representative, Relationship