McBride Vision Clinic

Patient Information Form

Patients First Name: ______________________ Middle: _____________ Last: ______________________

Date of Birth: ______________ Land Line ___________________Cell ___________________ Work ______

AddressCity _________________________ 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

Height_______/ _____ (Ft / In)
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)

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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	Lose 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		
Floaters	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		**Systemic Disease**	
Amblyopia	Y / N	Arthritis	Y / N
Blindness	Y / N	Cancer	Y / N
Cataracts	Y / N	Diabetes	Y / N
Color Blindness	Y / N	Heart Disease	Y / N
Eye Tumors	Y / N	High Blood Pressure	Y / N
Glaucoma	Y / N	Kidney Disease	Y / N
Macular Degeneration	Y / N	Lupus	Y / N
Retinal Detachment	Y / N	Stroke	Y / N
Strabismus	Y / N	Thyroid Disease	Y / N
Other Eye Conditions	Y / N		

Signature: ____ Date: ____________________________