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MORRILL & DIAMOND EYECARE

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New and Existing Patient Information

Please carefully fill out all of the following information, enabling us to provide you with the best possible care. We also will request to copy your Photo ID along with Vision and/or Medical Insurance Cards to properly file your insurance. Thank you.

Date:_____

First Name: _____ Middle Initial: _____ Last Name: _____

Address:_____ City:_____ State: _____ Zip:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____ Work Phone:(_____)_____

Gender: M / F Date of Birth:_____/_____/_____ Ethnicity: Caucasian/African American/Hispanic/Asian/_____

Patient's SSN: _____-_____-_____ Email Address:_____

Occupation:_____ Employer:_____ Pharmacy:_____

Primary Physician:_____ Specialist Requesting Notes of Visit:_____

Spouse Information- Name: _____ Date of Birth:_____/_____/_____ SSN:_____-_____-_____

Do You have Vision Insurance?: YES / NO Vision Insurance:_____

Policy Holder Name:_____ Birthday:_____/_____/_____ SSN:_____/_____/_____

Medical Insurance Primary:_____ Secondary:_____

Are you an: Existing Patient / New Patient (Previous Provider or Location:_____)

How is your vision currently corrected? Circle all that may apply.

Prescription Glasses / Readers / Back-Up Prescription Glasses / Prescription Sunglasses

Contact Lenses (Brand:_____ Solution:_____) / None of the above

Dilation: Dilation allows a more thorough examination of the inside of the eye. Our doctors recommend this test at the initial exam of each new patient and periodically at future exams. It is recommended that the patient have a driver as vision may be blurred following this procedure.

Circle your response:

Yes / No: I consent to dilation today.

Yes / No: I will reschedule dilation for a later date.

Alcohol Use: Daily / Occasionally / Former / Never / Other:_____

Tobacco Use (Smoker or Other) : Daily / Occasionally / Former / Never / Other:_____

Height:_____ **Weight:**_____

Have you been diagnosed with any of the following? Circle all that may apply.

Cataracts
Age-related Macular Degeneration
Glaucoma
Diabetes
Diabetic Retinopathy
Dry Eyes
Eye Infection or Inflammation
Floaters or Flashes of Light
Iritis or Uveitis
Retina Defects or Degenerations

Continued on next page...

Are you experiencing any of the following eye conditions? Circle all that may apply.

Redness Burning Itching Tearing Discharging

Are you currently having any of the following problems? Circle all that may apply.

Blurred Vision
Eyestrain
Eye Pain
Severe Sensitivity to Light
Headaches
Poor Night Vision
Bothersome Night Glare
Double Vision
Partial Loss of Vision
Total Loss of Vision

Symptoms and/or Conditions you currently have or previously have had in the past. Circle all that may apply.

Constitution:
Cancer
Fatigue Syndrome
Developmental Disabilities
Other:_____

Ear, Nose and Throat:
Dry Mouth
Hearing Loss
Sinusitis
Laryngitis
Other:_____

Neurological:
Epilepsy
Tumor
Migraines
Multiple Sclerosis
Stroke or CVA
Cerebral Palsy
Other:_____

Psychiatric:
Depression
Attention Deficit
Bipolar Disorder
Anxiety Disorder
Other:_____

Cardiovascular:
High Blood Pressure
Heart Disease
Congestive Heart Failure
Vascular Disease
Stroke or CVA
Other:_____

Respiratory:
Cigarette Smoker (current/former)
Sleep Apnea
Emphysema
Bronchitis
COPD
Asthma
Other:_____

Gastrointestinal:
Celiac Disease
Colitis
Crohn's Disease
Acid reflux
Ulcer
Other:_____

Genitourinary:
Benign Prostate Hypertrophy
Prostate Disease or Cancer
Chlamydia
Currently Nursing
Currently Pregnant
STD-Herpetic
Kidney Disease
Other:_____

Musculoskeletal:
Osteoarthritis
Muscular Dystrophy
Osteoporosis
Fibromyalgia
Ankylosing Spondylitis
Gout
Other:_____

Integumentary:
Eczema
Psoriasis
Rosacea
Herpes Zoster / Shingles
Herpes Simplex / Cold Sores
Other:_____

Endocrine:
Hormonal Dysfunction
Type 1 Diabetes
Type 2 Diabetes
Thyroid Dysfunction
Other:_____

Hematological / Lymphatic:
High Cholesterol
Ulcer
Anemia
Large Volume Blood Loss
Other:_____

Past Ocular History:
Cataracts
Glaucoma
Retinal Problems / Macula
Surgery
Lazy eye
Other:_____

Allergic / Immune:
HIV / AIDS
Rheumatoid Arthritis
Lupus
Environmental Allergies
Sjogren's Syndrome
Other:_____

Immediate Family Medical History: Fill in the blank with either Father, Mother, Brother, Sister, Son or Daughter.

Cancer:_____
Pre Diabetic:_____
Type 1 Diabetes:_____
Type 2 Diabetes:_____
High Blood Pressure:_____
Hyperthyroidism:_____
Hypothyroidism:_____
Cataracts:_____
Macular Degeneration:_____
Glaucoma:_____

List all Current Medications: Prescription and/or Over The Counter

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

List all Allergies to Medications and Food/Products:

_____ _____ _____
_____ _____ _____

Sensitivity To Latex: Yes / No

Patient's Signature:_____ **Date**:_____/_____/_____