CHEYNE EYE CENTER
Complete Optical Services

Patient Information

Full Name: _____ Preferred Name: _____

Date of Birth: _____ / _____ / _____ **Age:** _____ **Gender**: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone (Cell): _____ Phone (Home/Other): _____

Email: _____

Preferred Contact Method (check one):

☐ Text ☐ Email ☐ Call

Preferred Language: _____

Social Security # (optional, last four okay): _____

Driver's License #: _____

Employment Information (Optional)

Employer: _____

Position: _____

Work Phone: _____

Appointment Information

Date of Visit: _____ / _____ / _____ Doctor: _____

Reason for Today's Visit (Check all that apply):

☐ Comprehensive Eye Exam ☐ Contact Lens Exam ☐ Medical Eye Visit

☐ Vision Concerns ☐ Follow-up ☐ Other:

Were you referred to us by another provider? _____

Vision Insurance Information

Insurance Carrier: _____

Policy Holder Name: _____ Last Four SSN: _____

Policy Holder DOB: _____ / _____ / _____

Member ID: _____ Group Number: _____

Relationship to Patient: ☐ Self ☐Spouse ☐Child ☐Other

Medical Insurance Information

Medical Insurance Carrier: _____

Policy Holder Name: _____ Last Four SSN: _____

Policy Holder DOB: _____ / _____ / _____

Member ID: _____ Group Number: _____

Relationship to Patient: ☐ Self ☐Spouse ☐Child ☐Other

Secondary Insurance Information

Insurance Carrier: _____

Policy Holder Name: _____ Last Four SSN: _____

Policy Holder DOB: _____ / _____ / _____

Member ID: _____ Group Number: _____

Relationship to Patient: ☐ Self ☐Spouse ☐Child ☐Other

Medical History

Medical Conditions (check all that apply):

☐ Diabetes
☐ High Cholesterol
☐ Heart Disease
☐ Other: _____
☐ Hypertension
☐ Thyroid Conditions
☐ Autoimmune Disorders

Do you take Plaquenil (hydroxychloroquine)? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Primary Care Physician: _____

Physician City/State: _____

Last PCP Exam: _____

Pharmacy Used: _____

Diabetic History (if applicable)

How long diagnosed: _____

Treating Physician (if different): _____

Visit Frequency: _____

Last Hemoglobin A1c: _____

Times of day blood sugar runs high/low: _____

Family Medical History

☐ Diabetes	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ High Cholesterol	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Heart Disease	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Hypertension	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Thyroid Conditions	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Autoimmune Disorders	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Other: _____	○ Self	○ Mother	○ Father	○ Brother	○ Sister

Eye Health History

☐ Glaucoma suspect
☐ Inflammatory disorders
☐ Dry Eye
☐ Keratoconus
☐ Cataract
☐ Retinal issues (check all):
○ Retinal degeneration ○ Retinal hole ○ Retinal detachment
☐ Eye injury: _____
☐ Other: _____

☐ Patching
☐ Strabismus
☐ Amblyopia
☐ Nystagmus
☐ Age-related macular degeneration

Family Eye Health History

☐ Glaucoma	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Inflammatory disorders	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Dry Eye	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Keratoconus	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Cataract	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Patching	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Strabismus	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Amblyopia	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Nystagmus	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Macular degeneration	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Retinal issues	○ Self	○ Mother	○ Father	○ Brother	○ Sister
☐ Other: _____	○ Self	○ Mother	○ Father	○ Brother	○ Sister

Surgical History (Eye-Related and Non-Eye)

_____

_____

Status of Current Eye Health

Are you having any problems with your eyes? ☐ Yes ☐ No

If so, please describe: _____

When did the problem begin? _____

Which eye is affected? ☐ Left ☐Right ☐ Both

Severity? ☐ Mild ☐ Bothersome ☐ Painful

Is this a new condition? ☐ New Condition ☐ Return of Condition ☐ Ongoing Condition

Are any of the following symptoms part of the problem?

☐ Burning ☐ Loss of vision ☐ Headache

☐ Tearing ☐ Buildup ☐ Light sensitivity

☐ Red ☐ Itching ☐ Loss in sharpness

☐ Flashes ☐ Floaters ☐ Double vision

Is it associated with any of the following:

☐ Injury ☐ Infection ☐ Medical Condition ☐ Surgery ☐ Other

Have you taken steps to alleviate it?

☐ Medication ☐ Taking Drops ☐ Treated by another provider ☐ Other

Social History

Do you drink alcohol? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

If yes, what tobacco product? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless tobacco ☐ Other

Vision Correction History

Do you wear glasses? ☐ Yes ☐ No Age of glasses prescription: _____

Do you wear contacts? ☐ Yes ☐ No Age of contact lens prescription: _____

Brand of contacts: _____

Solution used: _____

How often do you sleep in them? _____

Wear cycle: Daily / Weekly / Bi-weekly / Monthly / Other: _____

Any problems/dissatisfaction with current glasses or contacts Rx? _____

Lifestyle & Vision Needs

Occupation: _____

Daily Screen Time: ☐ <2hours ☐ 2-4 hours ☐ 4-6 hours ☐ >6 hours

Hobbies/Activities: _____

Are you interested in:

☐ Contact Lenses ☐ Glasses

☐ Specialty Lenses ☐ Dry Eye Treatment Options

☐ LASIK/Other Surgery Consultation

Sudden or drastic vision changes since last visit? _____

Review of Systems (Check All That Apply)

Allergy/Immunology: ☐ None

☐ Drug Allergies	☐ Lupus
☐ Environmental Allergies	☐ Sjögren's Syndrome
☐ Rheumatoid Arthritis	

Respiratory: ☐ None

☐ Shortness of Breath	☐ Asthma

Hematology/Lymphatic: ☐ None

☐ Anemia	☐ Hypercholesterolemia
☐ Large Volume Blood Loss	☐ Ulcer

Cardiovascular: ☐ None

☐ Hypertension	☐ Congestive Heart Failure
☐ Heart Disease	☐ Stroke/CVA
☐ Chest Pain	☐ Palpitations
☐ Vascular Disease	

Gastrointestinal: ☐ None

☐ Heartburn	☐ Nausea

Psychological: ☐ None

☐ Depression	☐ Bipolar Disorder
☐ Attention Deficit	☐ Anxiety Disorder

Neurological: ☐ None

☐ Headaches	☐ Migraines
☐ Numbness	

General: ☐ None

☐ Fatigue	☐ Fever
☐ Weight Loss	☐ Joint Pain
☐ Muscle Aches	

Skin: ☐ None

☐ Rash	☐ Itching

Other: _____

Consent & Acknowledgments

I certify that the above information is true and correct to the best of my knowledge. I authorize the release of medical information necessary to process my insurance claims.

Signature: _____ Date: _____

Financial Responsibility

I understand that I am responsible for all charges not covered by insurance.

Signature: _____

Date: _____

Contact Lens Policy

I understand that a contact lens evaluation fee is separate from the comprehensive exam fee.

Signature: _____

Date: _____