TAYLOR EYECARE

Personal Health History Intake Form

Please fill out this form to the best of your knowledge. If you have any questions, please ask the front desk.
All information will remain confidential.

Name_____ Date of Birth_____ Today's Date_____
Address_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Cell Phone_____
Email Address_____ Medical Doctor_____
Social Security No._____ Marital Status_____
Occupation_____ Please circle one: Full time Part time Retired
How did you hear about our office?_____

Eye Medications (eye drops, vitamins, etc.)_____

Other Medications_____
_____
_____
_____

Prior Eye Surgeries_____
Other Recent Surgeries_____

Does anyone in your **immediate family** have any of the following eye diseases? If so, please list relationship.

Glaucoma	Y N	_____	High Blood Pressure	Y N	_____
Macular Degeneration	Y N	_____	Diabetes	Y N	_____
Lazy Eye	Y N	_____	Arthritis	Y N	_____

Do you smoke? Y N If yes, how many packs per day?_____ If yes, for how long have you smoked?_____
Do you drink alcohol? Y N If yes, how many drinks per week?_____
Do you use other recreational drugs? Y N
Height_____ Weight_____
Do you wear glasses? Y N Do you wear contact lenses? Y N

Do you currently or have you previously had any problems in the following areas? If yes, please explain.

Drug allergies or other allergies	Y N	_____
Cardiovascular (heart, blood pressure, etc)	Y N	_____
Endocrine (diabetes, thyroid, etc)	Y N	_____
Gastrointestinal (ulcers, acid reflux, etc)	Y N	_____
Genitourinary (bladder, prostate, etc.)	Y N	_____
Head (ear, nose, throat, etc.)	Y N	_____
Hematologic (blood disorders, etc.)	Y N	_____
Integumentary (skin, etc.)	Y N	_____
Muscles, Bones, Joints (arthritis, etc.)	Y N	_____
Neurological (multiple sclerosis, etc.)	Y N	_____
Psychiatric (anxiety, depression, etc.)	Y N	_____
Respiratory (asthma, bronchitis, etc.)	Y N	_____

Please see the back of this page to fill out insurance information.

Insurance Information

Medical Insurance _____

Policy Holder's Name_____

Policy Holder's Address_____

Policy Holder's Social Security Number_____

Policy Holder's Date of Birth_____

Policy Holder's ID Number_____

Policy Holder's Group Number_____

Vision Insurance_____

Policy Holder's Name_____

Policy Holder's Address_____

Policy Holder's Social Security Number_____

Policy Holder's Date of Birth_____

Policy Holder's ID Number_____

Policy Holder's Group Number_____