Forgues Eyecare & Associates

RETURNING PATIENT – CHANGES OR UPDATES

****DO NOT fill out this entire form. Submit only if you have changes or updates to share****

First, MI, Last, Name:

Date of Birth:

Street address:

City, State, Zip:

Cell Phone: Home Phone:

Email:

Gender: Male Female

Marital Status: Single Married Divorced Widowed Legally Separated

Occupation/Employer:

Language:

Race, Ethnicity:

Emergency Contact Name: Phone:

Guarantor Name (if person to bill other than patient):

INSURANCE INFORMATION

Vision Insurance: ID#:

Medical Insurance: ID#:

Primary Care Physician: Phone:

REASON FOR TODAY'S VISIT?

Do you currently wear contact lenses or want to wear contact lenses? Y N

For contact lens prescriptions: Per FDA regulations contact lens prescriptions are valid for one year. A contact lens evaluation is always a separate fee from your comprehensive eye examination; they include separate tests to measure the curvature of your eye, fit of the lens, and health of the eye. Contact lens fees may vary according to the complexity of the contact lens fit, or refit, and the type of lens used. If you have any questions regarding these fees, please ask a staff member or the doctor before your exam.

EYE HISTORY

Currently Wear glasses?	Y	N

Have you or a family member experienced, or been treated for, any of the following?
Circle all that apply.

Cataracts	Y	N	Family
Crossed Eye	Y	N	Family
Glaucoma	Y	N	Family
LASIK or RK	Y	N	Family
Lazy Eye	Y	N	Family
Macular Degeneration	Y	N	Family
Retinal Detachment	Y	N	Family

Are you currently experiencing, or have experienced, any of the following?
Circle all that apply.

Blurry vision	near or distance
Burning	
Discharge	
Double Vision	
Dryness / Dry Eyes	
Excess tearing/watering	
Eye infection	
Eye pain or soreness	
Floaters or spots	
Halos	
Headaches	
Itching	
Light flashes	
Redness	
Sandy or gritty feeling	

Are you pregnant or nursing?	**Y**	**N**
Do you smoke?	**Y**	**N**
Do you drink alcohol?	**Y**	**N**

Please email form to WorcAdmin@ForguesEyecare.com
or bring to your appointment.

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply. Circle all that apply.

AIDS/HIV	Y	N	Family
Allergies	Y	N	Family
Arthritis	Y	N	Family
Asthma	Y	N	Family
Blood/Lymph Disorder Cancer	Y	N	Family
Diabetes	Y	N	Family
Ears, Nose, Throat Conditions	Y	N	Family
Gastrointestinal Conditions	Y	N	Family
Heart Disease	Y	N	Family
High Blood Pressure	Y	N	Family
High Cholesterol	Y	N	Family
Kidney Disease	Y	N	Family
Lupus	Y	N	Family
Neurological Conditions	Y	N	Family
Psychiatric Disorder	Y	N	Family
Seizures	Y	N	Family
Skin Conditions	Y	N	Family
Stroke	Y	N	Family
Thyroid Dysfunction	Y	N	Family

CURRENT MEDICATIONS

(Prescription and over the counter)

ALLERGIES AND MEDICATION ALLERGIES