# Eye Associates of Carolina, P.A./Smith Optometric Eye Associates, P.A.
## Welcome To Our Office

**Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.**

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State Zip _____

Social Security Number _____ Date of Birth _____ Home Phone - Include Area Code _____ Day Phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____ If necessary, may we inform this person of your medical condition and/or diagnosis? _____

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient

☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

**PRIMARY INSURANCE INFORMATION**

Name and Address of Primary Insurance Company _____ City _____ State Zip _____

M ☐ F ☐ _____ _____

Insured's First Name MI Insured's Last Name

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

**Patient Relationship to Insured**

☐ Self ☐ Spouse ☐ Child ☐ Other

**Patient Status** ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

**SECONDARY INSURANCE INFORMATION**

Name and Address of Secondary Insurance Company _____ City _____ State Zip _____

M ☐ F ☐ _____ _____ _____

Insured's First Name MI Insured's Last Name

**Patient Relationship to Insured**

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____ ☐ Self ☐ Spouse ☐ Child ☐ Other

**Please Read:**

I authorize Eye Associates of Carolina, P.A./Smith Optometric Eye Associates, P.A. to obtain information from other physicians that they may feel is beneficial to their evaluation or treatment. I authorize the above practice to furnish information to insurance carriers and other doctors concerning my treatment. I understand that I am financially responsible for all charges whether or not paid by said insurance. All professional services rendered are charged to the patient. It is cusomtary to pay for services when rendered unless other arrangements have been made in advance. We accept cash, check, MC or Visa. I have read and understand the above statements and certify that the information provided is true and correct. I understand that this consent may be revoked in full or in part at any time. I also understand that I have the right to restrict the use and disclosure of any or all private health information.

**My signature below acknowledges my receipt and acceptance of the**
***Notice of Privacy Practice of Eye Associates of Carolina, P.A./Smith Optometric Eye Associates, P.A.***

Signature _____ Date _____

Name

# Eye Associates of Carolina, P.A.
## PATIENT HISTORY AND INFORMATION

**PRIMARY CARE PHYSICIAN**

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

**REFERRING PHYSICIAN**

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

**HEALTH HISTORY**

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

**EYE HISTORY**

| | | | | | |
|---|---|---|---|---|---|
| Glaucoma | O Yes O No | Dryness | O Yes O No | Strabismus (Crossed Eyes) | O Yes O No |
| Cataract | O Yes O No | Excess Tearing/Watering | O Yes O No | Blurred Vision Distance | O Yes O No |
| Macular Degeneration | O Yes O No | Eye Pain or Soreness | O Yes O No | Blurred Vision Near | O Yes O No |
| Retinal Detachment | O Yes O No | Foreign Body Sensation | O Yes O No | Distorted Vision (halos) | O Yes O No |
| Color Blindness | O Yes O No | Infection of Eye or Lid | O Yes O No | Double Vision | O Yes O No |
| Headaches | O Yes O No | Itching | O Yes O No | Floaters or Spots | O Yes O No |
| Glare/Light Sensitivity | O Yes O No | Mucous Discharge | O Yes O No | Fluctuating Vision | O Yes O No |
| Tired Eyes | O Yes O No | Drooping Eyelid | O Yes O No | Loss of Vision | O Yes O No |
| Amblyopia (Lazy Eye) | O Yes O No | Redness | O Yes O No | Loss of Side Vision | O Yes O No |
| Burning | O Yes O No | Sandy or Gritty Feeling | O Yes O No | | |

**GENERAL HEALTH CONDITION**

| | | | | | |
|---|---|---|---|---|---|
| Fever | O Yes O No | Respiratory (Asthma) | O Yes O No | Anxiety or Depression | O Yes O No |
| Weight Loss | O Yes O No | Gastrointestinal | O Yes O No | Thyroid, Diabetes | O Yes O No |
| Other Symptoms | O Yes O No | Kidney | O Yes O No | Blood/Lymph | O Yes O No |
| Ears,Nose,Throat | O Yes O No | Muscles,Bones,Joints | O Yes O No | Allergic | O Yes O No |
| Cardiovascular (high blood pressure etc.) | O Yes O No | Skin | O Yes O No | Are you? | ☐ Pregnant ☐ Nursing |
| | | Neurological (Multiple Sclerosis) | O Yes O No | | |

**FAMILY HISTORY**

| | | | | | |
|---|---|---|---|---|---|
| Amblyopia (Lazy Eye) | O Yes O No | Retinal Detachment | O Yes O No | High Blood Pressure | O Yes O No |
| Blindness | O Yes O No | Strabismus (Eye Turn) | O Yes O No | Kidney Disease | O Yes O No |
| Cataract(s) | O Yes O No | Arthritis | O Yes O No | Lupus | O Yes O No |
| Color Blindness | O Yes O No | Cancer | O Yes O No | Stroke | O Yes O No |
| Glaucoma | O Yes O No | Diabetes | O Yes O No | Thyroid Disease | O Yes O No |
| Macular Degeneration | O Yes O No | Heart Disease | O Yes O No | Others | O Yes O No |

Name

# Eye Associates of Carolina, P.A.

## MEDICAL HISTORY QUESTIONAIRE

### SOCIAL HISTORY

Current Occupation : _____ Years _____ Employer _____

### SPECTACLE LENS HISTORY

Do you use a computer? O Yes O No How many hours/day? _____ Distance from Computer? _____

Do you drive? O Yes O No Mileage to work each way? _____

Do you have glare problems? O Yes O No

Do you have visual difficulty when driving? O Yes O No

Do you have problems with night vision? O Yes O No

Do you currently wear glasses ? O Yes O No Since _____

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? O Yes O No _____

Do you wear sunglasses? O Yes O No Are your sun glasses your current prescription ? O Yes O No

### SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)
☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

### CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? O Yes O No

Have you ever tried to wear contact lenses? O Yes O No Reason for stopping? _____

Do you currently wear contact lenses? O Yes O No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

**Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT**

| | Right | Left | | Right | Left | | Right | Left |
|---|---|---|---|---|---|---|---|---|
| Lens Comfort | _____ | _____ | Distance Vision | _____ | _____ | Near Vision | _____ | _____ |

What Solutions do you use? Cleaner _____ Disinfectant _____ Enzyme _____

### SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? O Yes O No

Do you engage in regular exercise? O Yes O No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : O No O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack

Method of Tobacco Intake : O Smoking O Chewing

Do you use Illegal Drugs : O Yes O No

Hobbies/ Interests : _____