Up North Eye Care
Patient Information Form

This is a two-sided form

GENERAL INFORMATION

First, Last, MI, Preferred Name _____

Street Address _____

City, State, Zip _____

Phone, Type _____

Phone 2, Type _____

Date of Birth _____ Male/Female *(please circle)*

Occupation/Employer _____ *full-time / part-time*

Marital Status *married / single / divorced / legally sparated / widowed*

Emergency Contact Person and Phone _____

INSURANCE INFORMATION

Vision Insurance _____

Vision Insurance Member Name _____

Vision Insurance Member ID# _____

Vision Insurance Member Date of Birth _____

Primary Medical Insurance _____

Primary Member Name _____

Insurance ID# _____

Insurance Member Date of Birth _____

Primary Member Employer _____

Your Relationship to Primary Member *spouse / child / other (please exaplain)*

Secondary Medical Insurance _____

Secondary Medical Insurance Member Name _____

Secondary Medical Insurance ID# _____

Secondary Medical Insurance Policy #/Group ID# _____

Secondary Medical Insurance Member Date of Birth _____

Your Relationship to Secondary Medical Insurance Member *spouse / child / other*

MEDICATION ALLERGIES: _____

_____

please turn over

PATIENT HISTORY

EYE:

Date of Last Eye Exam: _____

Currently Wear Glasses? _____

Currently Wear Contacts? _____

Cataracts: Yes No Family

Lazy Eye: Yes No Family

Glaucoma: Yes No Family

Lasix or RK: Yes No

Retinal Detachment: Yes No Family

Macular Degeneration: Yes No Family

Previous Eye Surgeries: _____

Previous Eye Injuries: _____

SOCIAL:

Do you smoke? Yes No Amount _____

Do you vape? Yes No Amount _____

Do you use recreation Drugs? Yes No

What drugs to you use? _____

Do you drink Alcohol? Yes No

Do you drink ___ daily ___ occasional

MEDICAL :

Have you or a family member every been treated for:

AIDS/HIV: Yes No Family

Allergies: Yes No Family

Arthritis: Yes No Family

Asthma: Yes No Family

Blood/Lymph Disorder: Yes No Family

Cancer: Yes No Family

Diabetes: Yes No Family If so, Type I or Type II

Ears, Nose, Throat Conditions: Yes No Family

Gastrointestinal Conditions: Yes No Family

Heart Disease: Yes No Family

High Blood Pressure: Yes No Family

High Cholesterol: Yes No Family

Kidney Disease: Yes No Family

Lupus: Yes No Family

Neurological Conditions: Yes No Family

Psychiatric Disorder: Yes No Family

Seizures: Yes No Family

Skin Conditions: Yes No Family

Stroke: Yes No Family

Thyroid Dysfunction: Yes No Family

Are you currently esperiencing, or have experienced, any of the following: (*Please circle all that apply)*

Blurry Vision n*ear or distance*

Burning

Discharge

Double Vision

Dryness

Eye Infection

Eye Pain or Soreness

Floaters or Spots

Halos

Headaches

Itching

Light Sensitivity

Light Flashes

Redness

Sandy or Gritty Feeling

Excess Tearing/Watering

Signature: _____ Date: _____