# DaVinci Eye Care

1-Patient Demographics

Patient: _____ Date of Birth: _____ Age: _____
(Last Name) (First Name) (Initial)

Sex: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Other ☐ Divorced

Address: _____

_____
(City) (State) (Zip Code)

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Occupation: _____ Employed by: _____

Address: _____

_____
(City) (State) (Zip Code)

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone: _____

*Please list who we may contact in case of an emergency:*

| Name | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Your Primary Care Physician: _____ Phone Number: _____

Your Pharmacy: _____ Phone Number: _____

Medical Insurance Company: _____

Group Number: _____ ID Number: _____

Your Social Security Number: _____ Are you the primary card holder? _____

Primary card holder name: _____ Primary card holder DOB: _____

Primary card holder social security: _____

Secondary or Vision Insurance Company: _____

Group Number: _____ ID Number: _____

Primary card holder name: _____ Primary card holder DOB: _____

Primary card holder social security: _____

# DaVinci Eye Care

Patient: _____ Date : _____

## 2-Medical History Form

### Chief Complaint

How can we help you today? In this space please describe any signs and symptoms you are experiencing, such as dry eyes, loss of vision, headaches, eye redness, eye pain, floaters, flashes of light.

### Medications

Please list all medications you are currently taking, including eye drops:

Please list all allergies including drug allergies:

### Past, Family and/or Social History (1, 2E or 3N)

Please list all major hospitalizations and surgeries including dates: _____

Please list all family members who have diabetes, high blood pressure, thyroid disorder, glaucoma, and macular degeneration:

Do you use any of the following?

| | If yes please indicate how often: |
|---|---|
| Tobacco | □ Yes □ No |
| Alcohol | □ Yes □ No |
| Recreational Drugs | □ Yes □ No |

Have you ever been exposed to or infected with:

| | |
|---|---|
| Gonorrhea | □ Y □ N |
| Hepatitis | □ Y □ N |
| HIV | □ Y □ N |
| Syphilis | □ Y □ N |

### Review of Symptoms - Do you have a problem with ... *Please check each box* (1, 2, 10)

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| □ | □ | Double vision | □ | □ | Fever | □ | □ | Genitals | □ | □ | Headaches/Migraines |
| □ | □ | Glaucoma | □ | □ | Weight Loss | □ | □ | Kidneys | □ | □ | Stroke |
| □ | □ | Macular Degeneration | □ | □ | Heart Pain | □ | □ | Bladder | □ | □ | Seizures |
| □ | □ | Flashes/ floaters | □ | □ | High Blood Pressure | □ | □ | Anemia | □ | □ | Neurologic Disorders |
| □ | □ | Eye Surgery | □ | □ | Heart Disease | □ | □ | Bleeding Problems | □ | □ | Depression |
| □ | □ | Glare | □ | □ | Diabetes | □ | □ | Swelling | □ | □ | Asthma |
| □ | □ | Loss of Vision | □ | □ | Thyroid Problems | □ | □ | Skin | □ | □ | Shortness of Breath |
| □ | □ | Eye Injuries | □ | □ | Diarrhea | □ | □ | Breast | □ | □ | Emphysema |
| □ | □ | Dry Eyes | □ | □ | Constipation | □ | □ | Arthritis | □ | □ | Sinus problems |
| □ | □ | Lazy Eye | □ | □ | Ulcers | □ | □ | Muscle Pain | □ | □ | Chronic Cough |

Please report at additional medical history not listed above:

***I attest to the best of my knowledge the above information is correct. I will inform the doctors at DaVinci Eye Care of any changes at each visit. By typing your name below, it as binding as your legal signature.***

***Name:***_____***Date:***_____