LUKE EYE ASSOCIATES

Welcome! We appreciate you choosing us for your eye health needs.

Name_____ Date of Birth_____

Address_____City_____State____Zip_____

Home Phone_____ Work Phone_____ Email_____

Employer/Occupation_____Marital Status_____ How did you hear about us?_____

Do you have vision Insurance? Yes No Do you have Medical Insurance? Yes No

Insurance Company_____ Policy Holder_____

Relationship to Policy Holder_____ Policy Holder's DOB_____ SSN_____

Co-pays & Deductibles are required on date of service. We will bill your insurance but can't assure payment. You are fully responsible for payment.

Who is your family physician:_____

Last Eye Exam_____ By Whom_____

List any medications you are currently taking (Prescription or over-the-counter)_____

_____

List any medications you are allergic to_____

Are you pregnant or nursing? Yes No Do you wear glasses? Yes No Do you wear Contact lenses? Yes No

Your General Health	**Family Health History**	**Eye Health**	
Have you ever had or do you currently have… □Allergies □Heart Disease □High Blood Pressure □Cancer Type_____ □Diabetes □Gastrointestinal Disease □Headaches □Kidney Disease □Anemia □Skin Problems □Muscle Pain □Joint Pain □Arthritis Rheumatoid? Y N □Psychiatric Illness □Respiratory Disease □Thyroid Disease □Other _____ _____	Has anyone in your family had…. *Relationship* □Diabetes _____ □High Blood Pressure _____ □Cancer _____ □Arthritis_____ □Glaucoma _____ □Blindness _____ □Cataracts _____ □Crossed Eyes_____ □Lazy Eye _____ □MacularDegeneration _____ □None of the above **SOCIAL HISTORY** Do you…….. □Smoke Amount?_____ Years?_____ □Consume Alcohol Amount_____ □Use Street Drugs	Do you any of the following? □Glaucoma □Cataract □Macular Degeneration □Retinal Detachment □Amblyopia (Lazy Eye) □Strabismus (Crossed) □Blurred Distance Vision □Blurred Near Vision □Double/Distorted Vision □Eye Strain/Headaches □Glare/Light Sensitivity □Tired Eyes □Dryness □Sandy or Gritty □Redness □Excessive Tearing □Foreign Body Sensation □Mucus/Discharge □Loss of Vision □Floaters or Flashes □Night Vision Problems □Other_____	List any eye trauma or surgeries you have had List all other major injuries, surgeries or hospitalizations you have had