Fairview EyeCare, P.A.

WELCOME BACK FORM

Patient Name: _____

DOB: _____/_____/_____

Address: _____

Cell #: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____

E-Mail: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Reason for Visit: (*Eye Exam, Dry Eye, etc*): _____

_____

Do you currently wear: (circle or highlight) Glasses / Contacts / Both / None

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Personal / Family History:

Blindness: Yes / No / Family

Cataracts: Yes / No / Family

Glaucoma: Yes / No / Family

Diabetes: Yes / No / Family
(*If yes*) Last A1C: _____ Date: _____
Blood Sugar: _____ Date: _____

High Blood Pressure: Yes / No / Family

High Cholesterol: Yes / No / Family

Macular Degeneration: Yes / No / Family

Are you experiencing any of the following:

Itching: Yes / No

Allergies: Yes / No

Dry Eyes: Yes / No

Eye pain or irritation: Yes / No

Flashes or Floaters: Yes / No

Amblyopia / Strabismus: Yes / No

Injuries to Eye (*even as a child*): Yes / No
(*If yes*) Age: _____

Current Medications: _____

Medication/Food Allergies: _____

Tobacco: Yes / No Packs Per Week/Day: _____

Alcohol: Yes / No Drinks Per Wk/Day: _____

Narcotics: Yes / No

Height: _____ft _____in Weight: _____ lbs