Ephrata Family EyeCare, LLP
Where Vision is Precious Beyond Measure

____ (Init.)
☐ Photo ID   Today's Date ____________________

WELCOME TO OUR OFFICE

Name (Mr / Mrs / Miss) ______________________________ Date of Birth __________ M F (circle)
FIRST LAST MI

Street ______________________________ City ______________ State _____ Zip ________

Primary Phone ______________ (h w c) Alternate Phone ______________ (h w c) E-mail Address: ____________________

Spouse (or Parent's Name) ______________________ Employer (or School) ______________________

Occupation ____________________ How will you settle your account today? ___ Check ___ Cash ___ Credit Card

How did you first hear about our office? Referred by (Name): ____________ Please circle: Online Newspaper Other: ____

Medical Insurance ______________________ We do not participate in any vision plans. __________
(We do not bill frames, lenses, contacts to insurance) (Please initial your acknowledgement)
Does your medical insurance offer a healthy eye exam? Yes No

What is the major purpose of this visit? ______________ What sports to you participate in? ______________

How many hours per day do you spend on an electronic device? (computer, phone, tablet, etc.) ____________

Do you wear sunglasses? Yes No Are you interested in contact lenses? Yes No

Have you ever worn/are you currently wearing contacts? No Yes - What kind? __________ Solutions used ________

Name of physician ______________________ **Are you currently under the care of a physician? No Yes**

Please indicate if you are pregnant ____________

MEDICAL HISTORY

Allergies	Yes No	Eye Surgery	Yes No
Arthritis	Yes No	Kidney	Yes No
Asthma	Yes No	Cataracts	Yes No
Cancer	Yes No	Glaucoma	Yes No
Skin Disorder	Yes No	Diabetes	Yes No
Nerves	Yes No	Date Diagnosed ____	
Eye Diseases	Yes No	Type 1 2	
Heart Disease	Yes No	How Controlled	
High Blood Pressure	Yes No	Insulin Oral Diet	
Eye Injury	Yes No	A1C __________	
Lazy Eye	Yes No	Is it under control?	Yes No

Other ______________________________

FAMILY MEDICAL HISTORY

		Relationship
Blindness	No Yes	____________
Cataracts	No Yes	____________
Glaucoma	No Yes	____________
Diabetes	No Yes	____________
Heart Disease	No Yes	____________
Other	No Yes	____________

CURRENT MEDICATIONS & SUPPLEMENTS

____
____
____
____
____
____
____
____
____

Do you experience . . . .
(Vision Symptoms)

__ Blurry Near Vision (Reading)
__ Eye Strain
__ Fatigue
__ Trouble working up close
__ Other ____________
__ Blurry Distance Vision (TV, Driving)
__ Uncomfortable Glasses
__ Uncomfortable Contact Lenses

(Medical Symptoms)

__ Watery Eyes
__ Sensitivity to light
__ Headache
__ Objects floating in vision
__ Itchiness
__ Flashes of light
__ Dryness
__ Other ____________
__ Burning
__ Glare or Reflection
__ Gritty Feeling in Eyes
__ Spots
__ Sudden loss of vision
__ Jaw pain
__ Double Vision