McMillian Eye Care

Welcome To Our Office

Name:______________________________ Date:______________

Street:______________________________

City:__________ State:_____

Zip:______ Phone:____

Date of Birth:______________

Sex: Male______ Female_____

Social Security#:____________

Spouse:________________

Employer or School:__________

Work#:________________

Cell#:________________

Email Address:__________________________

Responsible Party, if other than patient

Name:__________________________

Address:________________________

Phone:__________ Date of Birth:__________

Social Security#:__________________

Vision Insurance:__________________

Medical Insurance:_________________

Primary Care Physician:______________

Address:________________________

Have you ever worn or are you currently wearing contact lenses? Yes______ No______

Are you interested in contact lenses? Yes______ No______

Are you interested in information concerning laser vision correction? Yes______ No______

Do you have prescription sunglasses? Yes______ No______

For the purpose of notifying me of my protected health information such as test results, appointments dates and times, or other necessary contacts. This person or persons will only be notified when I cannot be reached. I__________________________ permit McMillian Eye Care to contact

Name:____________________ Phone:______________ Relation:________

Name:____________________ Phone:______________ Relation:________

MCMILLIAN EYE CARE

Name:______________________________ **Height:**______________________

Date:______________________________ **Weight:**______________________

Circle any of the following medical conditions that you currently have

Medical History

Anxiety	Coronary Artery Disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Asthma	Diabetes	Leukemia
Atrial Fibrillation (Irregular Heartbeat)	End Stage Renal	Lung Cancer
Bone Marrow Transplantation	GERD	Lymphoma
BPH	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation
Colon Cancer	HIV/AIDS	Seizures
COPD	Hypercholesterolemia	Stroke

Other:____

Patient Medical Surgery History:____

Smoking History: **Current**________ **Former:**________ **Never:**_________

Circle any of the following ocular conditions that you currently have

Ocular History

Allergic Conjunctivitis	Blepharitis	Cataract
Corneal Dystrophy	Diabetic Retinopathy Background	
Diabetic Retinopathy Proliferative	Dry Eyes	Glaucoma
Macular Degeneration	Macular ERM	Narrow Angle
Ocular Hypertension	Pseudoexfoliation	PVD
Retinal Tear	Strabismus	Vitreous Floaters

Other:____

Patient Ocular Surgery History:____

Current Medications

Please list all medications you are currently taking including over the counter

Medication	Dosage	Frequency

Current Medications Allergies

Family History WHO/WHAT

	Mother	Father	Sister	Brother
Heart Disease				
Hypertension				
Diabetes				
Cataracts				
Glaucoma				
Blindness				
Lazy Eye				
Macular Degeneration				
Other:				
Other:				