

WELCOME TO BAKER FAMILY EYECARE

Mr. Mrs. Ms. Dr. Rev.	PERSONAL INFORMATION			Male	Female
Patient's Last Name	First Name	Middle Initial	Birth date	Social Security Number	
Street Address	City	State	Zip	Email:	
Primary Phone Number (Cell, Work, Home)	Secondary Phone Number (Cell, Work, Home)			Employer & Occupation	
Name of Vision Insurance Company	Policy Number/ Group Number			Who May We Thank For Referring You:	
Name of Medical Insurance Company	Policy Number/ Group Number			Policy Holder	SSN DOB

MEDICAL AND EYE HISTORY

Reason for Today's Visit:	Date of Last Eye Exam:
Do You Wear Glasses? Yes No If so, how often: Constantly Driving only Reading only Contacts Primarily Occasionally	Do You Wear Contacts? Yes No If so, Brand of Lenses? How often do you replace lenses? Daily 2weeks Monthly Yearly

Check all **EYE** conditions that apply to **YOU** and describe if necessary:

Eye Injuries _____ Eye Surgeries _____ Glaucoma Cataracts Macular Degeneration
 Blurred vision-Far Blurred vision-Near Dry Eyes Itchy/watery eyes Floaters or Spots Lazy or Crossed eyes Blindness
 Diabetic Retinopathy Retinal Detachment Other, Please describe: _____

Check all **MEDICAL** conditions that apply to **YOU** and describe if necessary: Diabetes High Blood Pressure Thyroid Disease Heart Disease

Cancer Head Trauma Kidney Disease High Cholesterol Other, Please describe: _____
 Current Medications: _____
 Allergies to Medications: _____

Check all **EYE and MEDICAL** conditions that apply to **YOUR FAMILY** and describe if necessary: Macular Degeneration Diabetes

High Blood Pressure Thyroid Disease Heart Disease Cancer Glaucoma Cataracts before the age of 50
 Other Eye Diseases _____ Other Inherited Diseases _____

NOTES (for doctor use):

FAMILY INFORMATION

Spouse: _____	Age: _____	Child's Name: _____	Age: _____
Child's Name: _____	Age: _____	Child's Name: _____	Age: _____

PRIMARY DOCTOR INFORMATION

Primary Care Doctor: _____	Phone Number: _____	Fax Number: _____
Address: _____	Last Physical Exam: _____	