Welcome to Norton Eye Care

Date: _____/_____/_____

Patient Information

Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Name: _____ Nickname: _____

Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III Credentials: ☐ MD ☐ OD ☐ DO ☐ DDS ☐ PHD

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Preferred Communication: ☐ Phone ☐ Email

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

Guardian: _____ Relationship: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

How did you hear about us?

☐ Drive by/Signage ☐ Advertisement ☐ Facebook/Twitter/Instagram ☐ Google ☐ Yelp
☐ Insurance ☐ CareCredit ☐ Doctor Referral: _____ ☐ Friend or Family: _____

Primary Care Physician: _____

Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Employer: _____ Occupation: _____

Sports/Hobbies: _____

Drink: ☐ Yes ☐ No Smoke: ☐ Yes ☐ No

Major Injuries/Surgeries: _____

Medications: _____

Allergies: ☐ Drug: _____ ☐ Environmental ☐ Latex

Blood Pressure: ____/____

Personal Medical History

Constitutional
- ☐ Fever
- ☐Weight loss/gain
- ☐ Fatigue
- ☐ Trauma
- ☐ Cancer
- ☐ Developmental Disabilities

Neurologic
- ☐ MS
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Migraine

Cardiovascular
- ☐ High Blood Pressure
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth

Psychiatric
- ☐ Depression
- ☐ ADD/ADHA
- ☐ Anxiety
- ☐ Bipolar Disorder

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD
- ☐ Benign Prostate Hypertrophy

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Herpes Simplex
- ☐ Thyroid Dysfunction
- ☐ Herpes Zoster/Shingles

Gastrointestinal
- ☐ Chrohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Ulcer
- ☐ High Cholesterol

Autoimmume

☐ Hormonal Dysfunction ☐ Osteoporosis ☐ Rheumtaoid arthritis ☐ Gout ☐ Sjogren's ☐ Lupus

Ocular/Eye History

☐Glaucoma ☐Cataract ☐Surgery ☐Patching ☐Inflammatory Disorder ☐Nystagmus

☐Strabismus ☐Amblyopia ☐Keratoconus ☐Injury ☐Dry Eye

☐Retinal Degeneration/Hole/Detachment ☐Age-Related Macular Degeneration ☐Other: _____

I wear: ☐ Glasses ☐ Contact Lenses Contact Brand: _____

How long do you wear your contacts before you throw them away? _____

Do you sleep in your contacts? ☐ Yes ☐ No

Contact Lens Solution: ☐ Opti-Free ☐ BioTrue ☐ Clear Care ☐ Renu ☐ Generic

☐ Other Eye Drops: _____

Family History

Medical
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid
- ☐ Other: _____

Ocular
- ☐ Glaucoma
- ☐ Cataract
- ☐ Surgery
- ☐ Patching
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Nystagmus
- ☐ Age-Related Macular Degeneration
- ☐ Inflammatory Disorder
- ☐ Retinal Degeneration/Hole/Detachment
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry Eye
- ☐ Other: _____