**Welcome To Clarity Eye Care**
Thank you for choosing our office for your vision care needs.

**GENERAL INFORMATION** Date_________________

First Name____________________________ MI______ Last Name_______________________________

Age______ Birthdate___________ Marital Status_________ Male / Female SS#_________________

Address__________________________________ City_______________ State_______ Zip__________

Primary Phone_____________________Hm Wk Cell Alternate____________________Hm Wk Cell

I am able to receive texting on my cell. YES NO

Preferred Language__________________________

E-Mail address______________________________________

**Race:**
__ American Indian or Alaskan Native ___ Asian
__Black or African American ___ Hispanic
__ Native Hawaiian/Pacific Islander ___ White

**Ethnicity:**
__Hispanic or Latin __ Non-Hispanic or Latino
__Hawaiian/Pacific Native Islander

Employer/School__________________________ Occupation/School Grade______________________

If a minor, name of parent or guardian_______________________________________________________

Emergency Contact_____________________________ Relation____________ Phone______________

Who may we thank for referring you? ______________________________________________________

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Do you wear glasses? Yes / No All the time / Sometimes / Work only / Reading only / Driving / Sunglasses

Do you wear contacts? Yes / No Would Like To Try Contacts______

Date of Last Medical Exam_____/_____/_____ Primary Physician/Clinic_________________________

Date of Last Visual Exam_____/_____/_____ Primary Physician/Clinic__________________________

Are you currently Pregnant/Nursing Yes / No

| **Have you ever been diagnosed with:** | Yes | No | When were you diagnosed? |
|---|---|---|---|
| Cataracts: | _____ | _____ | ___________________________ |
| Glaucoma: | _____ | _____ | ___________________________ |
| Macular Degeneration | _____ | _____ | ___________________________ |

**Please list any medications, supplements, eye drops and/or drugs that you are taking (including herbal):**
**See Attatched List:____**

1____________________For___________________ 6____________________For___________________

2____________________For___________________ 7____________________For___________________

3____________________For___________________ 8____________________For___________________

4____________________For___________________ 9____________________For___________________

5____________________For___________________ 10____________________For___ ________________

**PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS):** PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

| **Cardiovascular:** ____**None**<br>____High Blood Pressure<br>____Stroke<br>____Heart Disease<br>____Vascular Disease<br>____High Cholesterol<br>____Other: | **Endocrine:** ____**None**<br>____Non-Insulin Dependent Diabetes<br>____Insulin Dependent Diabetes<br>____Thyroid Problem<br>____Hormonal Dysfunction<br>____Other: | **Respiratory** ____**None**<br>____Asthma<br>____Bronchitis<br>____Emphysema<br>____COPD<br>____Sleep Apnea<br>____Other: |
|---|---|---|
| **Constitutional:** ____**None**<br>____Cancer<br>____Trauma/Large Volume Blood Loss<br>____Developmental Disability<br>____Other: | **Ocular** ____**None**<br>____Glaucoma<br>____Macular Degeneration<br>____Detached Retina<br>____Other: | **Psychiatric:** ____**None**<br>____ADHD<br>____Depression/Anxiety<br>____Schizophrenia<br>____Other: |
| **Neurological:** ____**None**<br>____Multiple Sclerosis<br>____Epilepsy<br>____Cerebral Palsy<br>____Tumor<br>____Other: | **Musculoskeletal:** ____**None**<br>____Osteoarthritis<br>____Fibromyalgia<br>____Muscular Dystrophy<br>____Ankylosing Spondylitis<br>____Other: | **Immunologic:** ____**None**<br>____AIDS or HIV<br>____Rheumatoid Arthritis<br>____Lupus<br>____Neurofibromatosis<br>____Other: |
| **Hematological:** ____**None**<br>____Anemia<br>____Leukemia<br>____Other: | **Gastrointestinal:** ____**None**<br>____Crohn's<br>____Colitis<br>____Other: | **Ear/Nose/Throat:** ____**None**<br>____Hearing Loss<br>____Upper Respiratory Infection<br>____Other: |
| **Dermatologic:** ____**None**<br>____Eczema<br>____Rosacea<br>____Psoriasis<br>____Other: | **Allergies/Reactions** ____**None**<br>Drug:<br><br>Environmental: | **Alcohol Use: Y N**<br>Amount:<br><br>**Tobacco Use: Y N**<br>Amount: |

## Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examinations rendered to me or my dependent to:________________________

## HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

I am aware of Clarity Eye Care's Notice of Privacy Practices. I would like a copy. Yes / No

**Patient Signature**___________________________________________ **Date**____________________

**Office Use Only Reviewed by:**

__________________________________________________ **Date**_________________

__________________________________________________ **Date**_________________