EYE CLINIC & AESTHETICS OF PROVO

Welcome to the Eye Clinic & Aesthetics of Provo!

(All information is always kept secure and confidential)

Today's Date: ____/____/_____

PATIENT INFORMATION

*Text & Email are for appointment reminders and internal communication only.

Patient's Name: (Last, First, Middle) _____ Preferred name:_____

Birthdate: _____/_____/_____ Age: _____ Birth Sex: ☐ F ☐ M Social Security#:_____

Address: _____ City:_____, State:_____, Zip:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____ *Text okay?: ☐Yes ☐No

Email Address: _____ How did you hear about us?:_____

Emergency Contact Name: _____ Relation: _____ Phone: ( ) _____

INSURANCE INFORMATION

Medical Insurance Name: _____Member ID#_____

Policy Holder Name, Date of Birth (If different than patient): _____

Vision Insurance Name: _____Member ID#_____

Policy Holder Name, Date of Birth (If different than patient): _____

Policy Holder SS# (for insurance verification): _____

Person responsible for payment **(If different from policy holder above):** Name:_____

Address: _____ City, State, Zip:_____ Phone:( )_____

PERSONAL EYE HISTORY

List any personal history of: crossed eyes, keratoconus, droopy eyelids, glaucoma, retinal disease, cataracts, eye infections, injuries or surgeries:_____

Have you had LASIK?: ☐ Yes ☐ No If no, are you interested in LASIK?: ☐ Yes ☐ No

List any EYE DROPS you use (artificial tears, prescription, ointments, allergy, etc.):_____

Do you wear glasses?: ☐ Yes ☐ No If yes, what is the current age of your lenses?:_____

Do you wear contacts?: ☐ Yes ☐ No If yes, what brand?:_____ If no, are you interested in contacts?: ☐ Yes ☐ No

PERSONAL MEDICAL HISTORY & SOCIAL HISTORY

Who is your Primary Care Provider (PCP)?: _____ PCP Telephone: ( )_____

List or provide us a copy of all MEDICATIONS you currently take (including oral contraceptives, aspirin, over the counter and home remedies):

_____

List MEDICATION ALLERGIES you have, if any: _____

If you are female, are you pregnant or nursing? ☐Yes ☐No Do you use any of the following?: Tobacco ☐ Alcohol ☐ Illegal Drugs ☐

FAMILY OCULAR / MEDICAL HISTORY

Please check any ***family*** history (living or deceased) with the following conditions: **(List Relationship)**

☐ **Unknown/Adopted**

☐ Crossed / Lazy Eye	_____	☐ Retinal Detachment	_____	☐ Diabetes	_____
☐ Glaucoma	_____	☐ Kerataconus	_____	☐ Heart Attack / Heart Disease	_____
☐ Macular Degeneration	_____	☐ Cancer	_____	☐ High Blood Pressure	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any chronic problems in the following areas:

	NO	YES	IF YES, EXPLAIN:
EYES (flashes/floaters, double vision, dry eye, infection, etc.)	☐	☐	_____
EAR, NOSE, MOUTH, THROAT (Dry mouth, sinus infections, etc.)	☐	☐	_____
RESPIRATORY (Asthma, COPD, etc.)	☐	☐	_____
ENDOCRINE (Thyroid, Diabetes, Kidney Disease, etc.)	☐	☐	_____
IMMUNE DISORDERS (Allergies, Hay Fever, Lupus, Rheumatoid)	☐	☐	_____
CARDIOVASCULAR (Hypertension, Heart Disease, Stroke, High Cholesterol)	☐	☐	_____
PSYCHIATRIC (Depression, Anxiety, etc.)	☐	☐	_____
BONES, JOINTS, MUSCLES (Arthritis, muscle/joint pain)	☐	☐	_____
NEUROLOGICAL (Headaches, Migraines, MS)	☐	☐	_____

Please fill out this symptom survey to help your doctor better understand your symptoms better.

How Often do you experience these symptoms?		1	2	3	4	5
	**Headaches** of *any* severity**,** usually worse later in the day	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯
	**Stiffness / pain in neck / shoulders** When you work at a computer or read	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯
	**Discomfort with Computer /Phone Use** In your eyes after long hours of looking at the screen	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯
	**Tired Eyes** With increasing feeling of eye fatigue throughout the day	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯
	**Dry Eye Sensation** more gritty/sandy when looking at screens or reading	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯
	**Light Sensitivity** Especially with brighter stronger lights like headlights	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯
	**Dizziness or Motion Sickness or Vertigo**	Never ◯	Not often ◯	Monthly ◯	Weekly ◯	Daily ◯

AESTHETICS & SKINCARE:

Patient Concerns: Please select all that may apply to you, if any:

- ☐ Fine Lines/Wrinkles
- ☐ Skin Texture
- ☐ Sagging or Puffy Eyelids
- ☐ Under Eye Circles
- ☐ Other? Please describe: _____
- ☐ Skin Laxity/Needs Tightening
- ☐ Age Spots
- ☐ Skincare
- ☐ Unwanted Hair