



Welcome to Southern Dutchess Eye Care LLP. We are delighted to provide professional vision care for your family member. Please take a moment to complete the following information. If you have any questions, do not hesitate to ask.

Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone - Include Area Code Work Phone (Parent/Guardian)

Email Address (Parent/Guardian)* Parent or Guardian(s) Name Person Responsible for Account

* Your email address may be used to communicate special eye care offers, practice news, or information useful to you. It will not be sold or released to third parties.

Emergency Contact Emergency Phone

How were you referred to our office?

Phone Book School Advertisement Patient (Please Name)
 Insurance Listing Drive By Other: _____ Doctor (Please Name)

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured Patient Status
 Self Child Other Full-Time Student Part-Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured
 Self Child Other

Please Read:

I request that payment of authorized Insurance benefits (including Medicare benefits) for any services furnished me, be made on my behalf to Brian D. Peralta OD, Brian Powell OD and/or Gary M. Weiner OD. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I acknowledge that I received a copy of the Southern Dutchess Eye Care Notice of Privacy Practices.

Signature (Parent or Guardian) Date

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Phone

Address of Primary Care Physician

City

State

Zip

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Phone

Address of Referring Physician

City

State

Zip

HEALTH HISTORY

What is the main reason for today's exam?

When was your last exam?

When was your last health exam?

Past illnesses or injuries:

Past Surgeries:

Current Medications:

Current Eyedrops:

Medicines that cause reactions or sensitivities:

Specific Allergies:

EYE HISTORY

- | | | | | | | | | |
|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|-------------------------|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dryness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Strabismus (<i>Crossed Eyes</i>) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cataract | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Excess Tearing/Watering | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blurred Vision Distance |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Macular Degeneration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye Pain or Soreness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blurred Vision Near |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Retinal Detachment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Foreign Body Sensation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Distorted Vision (<i>Halos</i>) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Color Blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infection of Eye or Lid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Double Vision |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Itching | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Floaters or Spots |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glare/Light Sensitivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mucous Discharge | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fluctuating Vision |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tired Eyes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Drooping Eyelid | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loss of Vision |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Amblyopia (<i>Lazy Eye</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Redness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Loss of Side Vision |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Burning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sandy or Gritty Feeling | | | |

GENERAL HEALTH CONDITION

- | | | | | | | | | |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory (<i>Asthma</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anxiety or Depression |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gastrointestinal | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Endocrine (<i>Thyroid, Diabetes</i>) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other Symptoms | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood/Lymph |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ears, Nose, Throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscles, Bones, Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergic |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiovascular
(<i>High Blood Pressure, etc.</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Skin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Are You Pregnant? |
| | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurological (<i>Multiple Sclerosis</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nursing? |

FAMILY HISTORY

- | | | | | | | | | |
|------------------------------|-----------------------------|-------------------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|---------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Amblyopia (<i>Lazy Eye</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Retinal Detachment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Strabismus (<i>Eye Turn</i>) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cataract(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Lupus |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Color Blindness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Macular Degeneration | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Others |

MEDICAL HISTORY QUESTIONNAIRE

SOCIAL HISTORY

Current School _____

Grade _____

SPECTACLE LENS HISTORY

Do you use a computer? Yes No How many hours/day? _____ Distance from Computer: _____

Do you drive? Yes No Mileage to work each way? _____ Do you have glare problems? Yes No

Do you have visual difficulty when driving? Yes No Do you have problems with night vision? Yes No

Do you currently wear glasses? Yes No Since: _____

Type of glasses

Glasses Owned

Full-time Part-time Distance Close Single Vision Back-Up Glasses Safety Glasses Sports Glasses

Have you had trouble in the past with glasses? Yes No _____

Do you wear sunglasses? Yes No

Are your sunglasses your current prescription? Yes No

SPECIAL EYEWEAR NEEDS

- Computer (special prescriptions, special anti-glare tints or coatings) Safety Glasses (lawn work, woodworking)
 Sports/Hobbies (racquet sports, baseball, swimming)

CONTACT LENS HISTORY

Have you ever tried to wear contact lenses? Yes No Reason for stopping? _____

Do you currently wear contact lenses? Yes No Since: _____

If not a contact lens wearer, are you interested in trying contact lenses at this time? Yes No

Type and brand of contact lenses? _____ Today's wearing time? _____

How many hours per day? _____ How many days per week? _____

Please rate the following on a scale of 1-10, with 1 being POOR and 10 being EXCELLENT

Lens Comfort R: _____ L: _____ Distance Vision R: _____ L: _____ Near Vision R: _____ L: _____

What solutions do you use? Cleaner: _____ Disinfectant: _____ Enzyme: _____

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc?) Yes No Do you engage in regular exercise? Yes No

Do you smoke? If yes, how much/often? No Occasional 1 per day 2-3 per day 4+ per day

Method of tobacco intake: Smoking Chewing Do you use illegal drugs or alcohol? Yes No

Hobbies / Interests: _____