EYE CARE & EYE WEAR CENTER of MAINE

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PATIENT DEMOGRAPHIC FORM

PLEASE FILL-IN ALL INFORMATION
(This information is required by new federal regulations)

(circle one): Mr. Mrs. Ms. Master Dr. Prof. Rev. Sister

NAME:_____SUFFIX:_____SEX: M / F

DOB:_____AGE:_____BIRTH STATE:_____

SSN (patient's social security number):_____

MOTHER'S MAIDEN NAME_____

PRIMARY LANGUAGE:_____

RACE: (circle one): American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, Other Race:_____

ETHNICITY (circle one): Hispanic or Latino, not Hispanic or Latino, Unknown

ADDRESS:

STREET:_____

CITY:_____STATE:_____ZIP:_____

COMMUNICATION:

PREFERENCE (call home, work, cell, e-mail), etc.):_____

HOME PHONE:_____

WORK PHONE:_____

CELL PHONE:_____ CARRIER (AT&T, Verizon, etc.):_____

E-MAIL:_____

Who is your primary care doctor?_____ Town:_____

NAME:_____DOB:_____ACCT:_____

1. Please complete all information. This will help the doctor in evaluating and treating your eye condition. This form is required for insurance billing.

PLEASE CHECK THE BOX IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight - sudden gain
- ☐ Weight - sudden loss

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

EAR, NOSE, THROAT
- ☐ Dizziness
- ☐ Hearing Loss

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema

GASTROINTESTINAL
- ☐ Diverticulitis
- ☐ Hepatitis A / B / C

GENITOURINARY
- ☐ Frequent Urination
- ☐ Prostate Cancer

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Sjogrens Syndrome
- ☐ Systemic Lupus

PSYCHIATRIC
- ☐ Depression

INTEGUMENTARY
- ☐ Skin Cancer
- ☐ Skin Rash

NEUROLOGICAL
- ☐ Migraines
- ☐ Paralysis
- ☐ Stroke

ENDOCRINE
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

HEMATOLOGIC
- ☐ Anemia
- ☐ Leukemia

IMMUNOLOGIC
- ☐ HIV / AIDS
- ☐ Autoimmune Disorder

_____

EYE HISTORY

Do you have
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Lazy Eye (Amblyopia)
- ☐ Dry Eye
- ☐ Eye Surgery

FAMILY HISTORY (Parents / Grandparents / Brothers / Sisters)

Does anyone in your family have any of the following? Who?
- ☐ Glaucoma_____
- ☐ Macular Degeneration (ARMD)_____
- ☐ Blindness_____
- ☐ Lazy Eye (Amblyopia)_____
- ☐ Diabetes_____
- ☐ Eye Surgery_____

MEDICATIONS: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES TO MEDICATIONS:_____

ENVIRONMENTAL ALLERGIES:_____

Are you interested in contact lenses?_____Do you currently wear contact lenses?_____

Do you smoke?
- ☐ Smoker
- ☐ Former smoker
- ☐ Never a smoker

Please read:

Eye Care & Eye Wear Center of Maine recommends that you do not smoke. Smoking can contribute to macular degeneration and cataracts.