Legacy Eyecare, McPherson

100 W Kansas, Suite 202, McPherson, KS 67460 (620) 241-5810

Welcome to our office. Please complete this form to the best of your knowledge.
The information you give will enable us to provide you with total eye care for you and your family.

General Information:

Today's Date __/__/___

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F

☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian

Patient Name____________________________________Social Security Number____-____-_______
First Middle Last
Home Address____
Street City State Zip
Date of Birth___/___/____ Home Phone# (____)____-______ Cell Phone #(____)____-______
Email Address: ____
Your Occupation____________Employer___________________ Work # (____)____-______
Spouse's Name______________ Employer____________________ Work # (____)____-______
Date of Last Eye Exam_____________ Previous Eye Doctor Seen___________________
Date of Last Medical Exam__________ Name of Medical Doctor____________________
Emergency Contact___________________Relationship________________Phone (____)____-______
Email address:____

Guardian Information: (Complete if under 18)

Mother's Name_________________________________
Address_______________________________________
Phone # Cell(___)____-______ Home(___)____-______
SSN # ____-____-_____ DOB___/___/______
Employer______________________________________.
Address_______________________________________.
Work# (_______)_______________________________.

Father's Name_________________________________
Address_______________________________________
Phone # Cell (___)____-______Home(___)____-_____
SSN # ____-____-______ DOB ____/____/______
Employer______________________________________.
Address_______________________________________.
Work# (_____)_________________________________.

Billing Information (if different from patient):

Name of Person Financially Responsible for Account_________________________________
Relationship to Patient_______________ SSN____-____-______ DOB___/___/______
Home Phone # (____)____-_____ Work Phone # (____)____-______
Address____
Street City State Zip

Insurance:

Insured by: Father Mother Self Spouse Grandparent Other _____________
Primary Insurance Company ________________Policy Holder_____________ID#_____________
SSN____-____-______&DOB___/___/_____ Place of Employment _______________________
Home Phone # (____)____-______ Work Phone # (____)____-______
Address____
Street City State Zip
Secondary Insurance Company_______________Policy Holder_______________ID#_____________
SSN____-____-______&DOB___/___/_____

I do hereby authorize the release of any medical information necessary to process all claims, and request payment of any medical benefit be paid to Legacy Eyecare.

X________________________________ _____________ __________________________________
Signature of Patient or Patient Representative Date Relationship of Patient Representative to Patient

REVIEW OF SYSTEMS

Do you have any problems in the following areas:

CONSTITUTIONAL	No	Yes	?
Fever	☐	☐	☐
Weight loss/ gain	☐	☐	☐
Cancer `	☐	☐	☐
EYES			
Frequent infections	☐	☐	☐
Droopy eyelids	☐	☐	☐
Eyelid matting	☐	☐	☐
Glare/halos	☐	☐	☐
Sudden loss of vision	☐	☐	☐
Loss of central vision	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Blurry vision	☐	☐	☐
Dryness/burning	☐	☐	☐
Itching	☐	☐	☐
Corneal disease	☐	☐	☐
Crossed/lazy eyes	☐	☐	☐
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Retinal disease	☐	☐	☐
Macular degeneration	☐	☐	☐
Optic neuritis	☐	☐	☐
Eye injury	☐	☐	☐
EARS, NOSE, MOUTH, THROAT			
Difficulty hearing	☐	☐	☐
Dizziness	☐	☐	☐
Sinus Congestion	☐	☐	☐
Dry throat or mouth	☐	☐	☐

CARDIOVASCULAR	NO	Yes	?
Chest pain	☐	☐	☐
Heart attack	☐	☐	☐
Heart valve disease	☐	☐	☐
Pacemaker	☐	☐	☐
Coronary artery disease	☐	☐	☐
Leg pain with walking	☐	☐	☐
High blood pressure	☐	☐	☐
High cholesterol	☐	☐	☐
RESPIRATORY			
Wheezing	☐	☐	☐
Chronic cough	☐	☐	☐
Shortness of breath	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
GENITOURINARY			
Frequent urination	☐	☐	☐
Kidney stones	☐	☐	☐
Discharge from genitals	☐	☐	☐
Frequent infections	☐	☐	☐
ENDOCRINE			
Diabetes	☐	☐	☐
Hair loss	☐	☐	☐
Thyroid problems	☐	☐	☐
Hepatitis	☐	☐	☐
INTEGUMENTARY			
Skin growths/lesions	☐	☐	☐
Skin cancer	☐	☐	☐
Recurrent rashes	☐	☐	☐

GASTROINTESTINAL	No	Yes	?
frequent diarrhea	☐	☐	☐
MUSCULOSKELETAL			
Osteoporosis	☐	☐	☐
Chronic low back pain	☐	☐	☐
Joint pain	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Seizures	☐	☐	☐
Dizziness/vertigo	☐	☐	☐
Multiple sclerosis	☐	☐	☐
Stroke	☐	☐	☐
HEMATOLOGICAL/LYMPHATIC			
Bleeding problems	☐	☐	☐
Anemia	☐	☐	☐
Leukemia/lymphoma	☐	☐	☐
Jaundice	☐	☐	☐
ALLERGIC/IMMUNOLOGIC			
Seasonal allergies	☐	☐	☐
Sjogren's disease	☐	☐	☐
HIV/AIDS	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Lupus	☐	☐	☐
PSYCHIATRIC			
Drug addiction	☐	☐	☐
Alcohol addiction	☐	☐	☐
Depression	☐	☐	☐

MEDICAL HISTORY

List any medications you take and dosage (including prescription, over the counter, and eye medications) or attach list:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Do you have any allergies to medications? ☐ no ☐ yes ____

List all surgeries, hospitalizations and/or eye injuries you have had:

________________________________ ________________________________

________________________________ ________________________________

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes **Do you wear contact lenses?** ☐ no ☐ yes

FAMILY HISTORY

Please note any family history(parents, grandparents, siblings, children, living or deceased) for the following conditions:

SYSTEMIC	No	Yes	?	Relationship
Diabetes	☐	☐	☐	__________
Heart Disease	☐	☐	☐	__________
High Blood Pressure	☐	☐	☐	__________
Stroke	☐	☐	☐	__________
Cancer	☐	☐	☐	__________
Lupus	☐	☐	☐	__________
Rheumatoid arthritis	☐	☐	☐	__________
Thyroid disease	☐	☐	☐	__________

OCULAR	NO	YES	?	Relationship
Blindness	☐	☐	☐	__________
Corneal Disease	☐	☐	☐	__________
Corneal transplant	☐	☐	☐	__________
Crossed/lazy eyes	☐	☐	☐	__________
Glaucoma	☐	☐	☐	__________
Cataracts	☐	☐	☐	__________
Retinal Detachment	☐	☐	☐	__________
Macular Degeneration	☐	☐	☐	__________

SOCIAL HISTORY

Do you live alone? ☐ no ☐ yes

Do you use illegal or "street" drugs? ☐ no ☐ yes

Do you drive? ☐ no ☐ yes

Do you use alcohol? ☐ no ☐ yes

Do you use tobacco products ☐ no ☐ yes

If yes, how much?______________________