Welcome to the Office of Dr. Elinor Descovich
Please complete front & back – thank you.

Patient Information

Today's Date ______________________________

Last Name _________________________________

First ______________________________MI ____

Street ____________________________________

City _______________ State ____ Zip Code______

Home Phone ______________________________

Work Phone ______________________________

Cell Phone_________________________________

Patient's Social Security No.__________________

Date of Birth ___________________Age ________

Sex M F

Employer (or School) ________________________

Occupation (or Grade) _______________________

Spouse (or Parent's Name) ___________________

Email Address ____________________________

Date of Last Eye Exam_________________________

What is the purpose of this visit?

____

____

____

Whom may we thank for referring you to our office?
Name of friend or relative ______________________

If not referred, how did you choose our office?

- ❑ Another Dr.________________________
- ❑ Insurance list or website___________________
- ❑ Saw Sign/Building
- ❑ Newspaper_____________________________
- ❑ Yellow Pages: Which directory? _____________
- ❑ Web Page: Which Web Site? ________________
- ❑ Other _________________________________

Insurance Information

Vision Insurance_______________________________

Subscriber Name_______________________________

Subscriber SSN/ID_____________________________

Subscriber Birth Date__________________________

Primary Medical Insurance______________________

Subscriber Name_______________________________

Subscriber SSN/ID_____________________________

Subscriber Birth Date__________________________

Do you have secondary insurance?
❑ Yes ❑ No

Do you participate in a flex spending account?
❑ Yes ❑ No

Lifestyle Questions

Do you……(check box if your answer is yes)

- ❑..work at a computer? How many hours/day?_____
- ❑..participate in sports?
- ❑..have trouble with glare or reflections?
- ❑..trouble seeing at night?
- ❑..spend time outdoors? How much? _____Hrs/week
- ❑..have prescription sunwear?
- ❑..think you might benefit from thinner, lighter lenses?
- ❑..prefer not to wear your glasses at times?
- ❑..have family members in need of eyecare?

Have you ever tried contact lenses? ❑ Yes ❑ No
If no, are you interested in trying them? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?___________________________________
Solutions used_________________________________

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Our goal is to provide comprehensive, professional eye care for you and your family in a personal and friendly setting. We thank you for putting your trust in our services, and will strive to provide you with the highest quality of vision care.

Name____Date____________

Patient Medical History

Name of Family Physician__________________________
Town____
Date of Last Physical Check-up_____________________

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)______________________________
____
____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?____________________________
____

Are you pregnant? ❑ Yes ❑ No
Have you had any surgery? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
Heart	❑	❑
Headaches	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Lung or breathing problems	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Other (please describe)______________________________

Patient Eye History

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Eye strain
- ❑ Double Vision
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Crossed eye/Eye turn
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Retinal Detachment
- ❑ Iritis/Uveitis
- ❑ Eye Infections
- ❑ Flashes of light
- ❑ Floaters/Spots
- ❑ Eye Injury
- ❑ Other eye disorders______________________________
- ❑ Eye surgery
- ❑ Burning
- ❑ Itchiness
- ❑ Grittiness
- ❑ Tearing
- ❑ Dry Eye
- ❑ Corneal Abrasions

❑ None of the above

Family Medical/Eye History (Check all that apply)

Is there a FAMILY history of any of the following?

	Relationship (e.g. parents, sisters, brothers, aunts, uncles etc.)
Glaucoma	❑____________________
Cataracts	❑____________________
Corneal Problems	❑____________________
Macular Degeneration	❑____________________
Retinal Problems	❑____________________
Lazy Eye	❑____________________
Blindness	❑____________________
High Blood Pressure	❑____________________
Diabetes	❑____________________
Heart Disease	❑____________________
Cancer	❑____________________
Thyroid	❑____________________
Any other health issues	❑____________________
None of the above	❑____________________

All patients: Dilating drops may be needed as part of your eye health exam. Blurry reading vision and light sensitivity can last a few hours. If you do NOT want this test done, please initial here___________

I consent to this office's use and disclosure of my protected health information to carry out my treatment, payment and healthcare. I have been given a copy of the office health information privacy practices (you can revoke this consent with written notice). Signature______________________