

# Family Eyecare Center

**DR. BARRY J. JOSE**  
**DR. RYAN P. LEMPP**  
**OPTOMETRISTS**  
Council Bluffs: **712-323-5213**  
Bellevue: **402-964-2700**  
The Right Place to Go....to See

## ***WELCOME***

to our office.....

We are happy you have  
chosen us for your professional  
vision care.

TODAY'S DATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX M F  
PATIENTS NAME \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS M W S  
ADDRESS \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_  
HOME PHONE# \_\_\_\_\_ NAME OF INSURED \_\_\_\_\_  
DAYTIME # \_\_\_\_\_ OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE  
EMPLOYER \_\_\_\_\_  
OCCUPATION \_\_\_\_\_  
PARENT'S NAME (if child) \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_  
POLICY # \_\_\_\_\_  
IS THIS YOUR FIRST VISIT TO OUR OFFICE? YES NO  
REASON FOR TODAY'S VISIT:  
ROUTINE VISION \_\_\_\_\_ EMERGENCY \_\_\_\_\_  
CONTACT LENS \_\_\_\_\_ OTHER \_\_\_\_\_  
HOBBIES OR SPECIAL INTEREST WITH SPECIAL VISION REQUIRMENTS \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US \_\_\_\_\_

### **Notice of Privacy Practice Guidelines:**

I acknowledge that I have read and understood the privacy guidelines of Family Eyecare Center.

\_\_\_\_\_ Date \_\_\_\_\_  
SIGNATURE

Code

Recall

### PATIENT MEDICAL HISTORY

<b>EYES:</b> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Other (specify)	<b>ENDOCRINE:</b> <input type="checkbox"/> Diabetes (Insulin, Medication) <input type="checkbox"/> Thyroid disorder <input type="checkbox"/> Other (specify)
<b>ALLERGIES/IMMUNE:</b> <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Steroids <input type="checkbox"/> Itchy, burning, watery eyes <input type="checkbox"/> Other (specify)	<b>NEUROLOGICAL:</b> <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> M.S. <input type="checkbox"/> Other (specify)
<b>CARDIOVASCULAR:</b> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart Trouble <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Other (specify)	<b>PSYCHIATRIC:</b> <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety disorder <input type="checkbox"/> Other (specify)
<b>RESPIRATORY:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Other (Specify)	<b>GASTROINTESTINAL:</b> <input type="checkbox"/> Ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Other (specify)
<b>HEAD/EAR/THROAT:</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Sinusitis <input type="checkbox"/> Dizziness <input type="checkbox"/> Other (specify)	<b>SKIN and BREAST:</b> <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Breast cancer (chemo) <input type="checkbox"/> Other (specify)
<b>MUSCULO-SKELETAL:</b> <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Other (specify)	<b>GENITOURINARY:</b> <input type="checkbox"/> Kidney or bladder disease , Specify <input type="checkbox"/> STD <input type="checkbox"/> Other (specify)

### PATIENT/FAMILY HISTORY

<b>PAST HISTORY:</b> <input type="checkbox"/> Eye surgeries <input type="checkbox"/> Eye injuries <input type="checkbox"/> Treatments that may affect vision Specify:	<b>FAMILY HISTORY:</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Glaucoma Who:
<b>MEDICATIONS:</b>    	