

Family Eyecare Center

**DR. BARRY J. JOSE
DR. RYAN P. LEMPP
DR. BRAD CARPENTER**

WELCOME

to our office.....

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

OPTOMETRISTS

**Council Bluffs: 712-323-5213
Bellevue: 402-964-2700
The Right Place to Go....to See**

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.

SIGNATURE Date _____

Code

Recall

PATIENT MEDICAL HISTORY

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

PATIENT/FAMILY HISTORY

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