KEENE EYE CARE

338 Main Street, Keene, NH 03431
P: 603-357-4090
F: 603-357-5081
frontdesk@keeneeyecare.com

Demographics:

Last Name, First Name	
Preferred Name	
Date of Birth	
Gender	
Mailing Address	
City, State, Zip Code	
Preferred Phone	
Secondary Phone (Optional)	
Email Address	
Emergency Contact & Phone Number	

Insurance Information:

Primary Medical Insurance	
Insurance Member ID #	
Subscriber Name/DOB	
Relationship to Subscriber	
Secondary Medical Insurance	
Insurance ID #	
Subscriber Name/DOB	
Relationship to Subscriber	

Current Medications & Doses **(Prescription & over the counter)**	**Allergies** **(Drug and other)**

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Medical History

Height	
Weight	
Do you smoke currently?	
Have you ever smoked?	
Are you currently pregnant or nursing?	

Have you or a family member experienced/been treated for any of the following? Circle all that apply.

	You	**Family**
AIDS/HIV	Yes / No	Yes / No
Arthritis	Yes / No	Yes / No
Asthma	Yes / No	Yes / No
Blood/Lymph Disorder	Yes / No	Yes / No
Cancer	Yes / No	Yes / No
Diabetes	Yes / No	Yes / No
Ears/Nose/Throat Conditions	Yes / No	Yes / No
Gastrointestinal Conditions	Yes / No	Yes / No
Heart Disease	Yes / No	Yes / No
High Blood Pressure	Yes / No	Yes / No
High Cholesterol	Yes / No	Yes / No
Kidney Disease	Yes / No	Yes / No
Lupus	Yes / No	Yes / No
Neurological Conditions	Yes / No	Yes / No
Psychiatric Disorder	Yes / No	Yes / No
Seizures	Yes / No	Yes / No
Skin Conditions	Yes / No	Yes / No
Stroke	Yes / No	Yes / No
Thyroid Dysfunction	Yes / No	Yes / No

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Eye History:

Date of Last Eye Exam	
Currently Wear Glasses?	
Currently Wear Contacts? **If yes, what brand/ strength?**	
Reason for today's visit?	

Have you or a family member experienced or been treated for any of the following? Circle all that apply.

	You	**Family**	**If yes for family, who?**
Cataracts	Yes / No	Yes / No	
Crossed Eye	Yes / No	Yes / No	
Glaucoma	Yes / No	Yes / No	
LASIK or RK	Yes / No	Yes / No	
Lazy Eye	Yes / No	Yes / No	
Macular Degeneration	Yes / No	Yes / No	
Retinal Detachment	Yes / No	Yes / No	

Are you experiencing/have experienced any of the following? Check all that apply.

Blurry Vision If yes:	Yes / No Near or Distance	Floaters or Spots	Yes / No
Burning	Yes / No	Halos	Yes / No
Discharge	Yes / No	Headaches	Yes / No
Double Vision	Yes / No	Itching	Yes / No
Dryness	Yes / No	Light Flashing	Yes / No
Excess Tearing/Watering	Yes / No	Light Sensitivity	Yes / No
Eye Infection	Yes / No	Redness	Yes / No
Eye Pain or Soreness	Yes / No	Sandy or Gritty Feeling	Yes / No