Welcome to the Office of Dr. Elinor Descovich Please Complete front and back – thank you.

Patient Information

Today's Date_____

Last Name_____

First_____ MI_____

Street _____

City_____State_____ Zip_____

Home Phone_____

Work Phone_____

Cell Phone _____ Text ☐ Yes ☐ No

Patient Social Security No._____

Date of Birth_____Age_____

Sex M F

Email Address_____

May we email you? ☐ Yes ☐ No

Employer (Or School) _____
Occupation (Or Grade) _____
Spouse (Or Parent) _____

Preferred Language:

☐ English ☐ Spanish ☐ Other_____

Ethnicity: (please choose one)

☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: (please choose one)

☐ American Indian/Alaska Native
☐ Asian
☐ Black
☐ Native Hawaiian/Pacific Islander
☐ Unknown
☐ White
☐ Other _____

Date of Last Eye Exam _____

Height_____
Weight _____

What is the purpose of this visit?
_____
_____
_____

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
If yes:
Secondary Medical Insurance_____
Subscriber Name_____
Subscriber SSN/ID_____
Subscriber Birth Date_____

Do you have 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 reflection?
☐…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 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

Whom may we thank for referring you to our office?
☐ Name of friend or relative _____
☐ Insurance List ☐ Newspaper
☐ Saw Sign/Building ☐ Webpage
☐ Newspaper
☐ Yellow pages: which directory?_____
☐ Another doctor _____
☐ Other _____

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Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List all medications including eye drops, birth control pills, and vitamins. Include the *strength and dose*)

_____
_____
_____

Allergies to medications? ☐ Yes ☐ No
If yes, what medications? _____
Side effects? _____

Are you pregnant? ☐ Yes ☐ No
Have you had any surgery? ☐ Yes ☐ No
If yes, what? _____
Do you use cigarettes/tobacco? ☐ Yes ☐ No ☐ Never
How often? _____ ☐ Former smoker
Do you drink alcohol? ☐ Yes ☐ No
What? _____

Patient Eye History

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

☐ Blurry Vision
☐ Eye Strain
☐ Glaucoma
☐ Macular Degeneration
☐ Cataracts
☐ Floaters/Spots
☐ Flashes of Light
☐ Sensitivity to light
☐ Crossed Eye/Eye turn
☐ Lazy Eye
☐ Total Vision Loss
☐ Dry Eye
☐ Discharge
☐ Redness
☐ Eye Injury
☐ Eye Pain
☐ Itchiness
☐ Eye Infections
☐ Iritis/Uveitis
☐ Night glare
☐ Poor night vision
☐ Double Vision
☐ Retinal Detachment
☐ Tearing

☐ NONE OF THE ABOVE

New Paltz Eye Care
Elinor B Descovich, OD, PC

Patient Medical History

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

	YES	NO
Allergies (Environmental)	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Cancer **Type:**	☐	☐
Cholesterol	☐	☐
Diabetes **Type I OR Type II**	☐	☐
Digestive **Specify**	☐	☐
ENT **Specify**	☐	☐
Sinus	☐	☐
Genitourinary	☐	☐
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Integumentary (Skin)	☐	☐
Kidney	☐	☐
Migraines	☐	☐
Osteoporosis	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Thyroid **Hyper OR Hypo**	☐	☐
Other		

Family Medical/Eye History (Check all that apply)

Is there a FAMILY history of any of the following?

	Relationship (parents, siblings, etc)
Cataracts	☐_____
Glaucoma	☐_____
Macular Degeneration	☐_____
Lazy Eye	☐_____
Blindness	☐_____
Cancer	☐_____
Diabetes Type I	☐_____
Diabetes Type II	☐_____
High Blood Pressure	☐_____
Hypothyroidism	☐_____
Hyperthyroidism	☐_____
Other	☐_____
NONE OF THE ABOVE	☐_____