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

Last Four 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 ____

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

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 ☐ 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

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	☐ ____________________