113 Center Street ● Chicopee, Massachusetts 01013 ● (413) 592-7777

Patient Information

First Name _____ Last Name_____

Address _____

City _____ State _____ Zip Code _____

DOB (mm/dd/yyyy) _____/_____/_____ Last 4 of SSN# _____

Gender: _____ Preferred Phone# Cell ☐ Home ☐ Work ☐

Cell:_____ Home:_____ Work:_____

Email:_____

Occupation: _____

Preferred Pharmacy: _____

Insurance Information

Do you have health insurance Yes ☐ No ☐

If yes, insurance carrier _____

Insurance Subscriber _____ DOB ____/____/_____

Subscriber ID or SSN# _____

Is the reason for your visit today a result of an accident at work? Yes ☐ No ☐

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions? Please circle Y (yes) or N (no) for each:

Constitutional
Y / N Developmental Disabilities
Y / N Cancer; Year(s): _____
Y / N Fatigue Syndrome
Y / N Other: _____

Ear/Nose/Mouth/Throat
Y / N Hearing Loss
Y / N Sinusitis
Y / N Dry Mouth
Y / N Laryngitis
Y / N Other: _____

Neurological
Y / N Multiple Sclerosis
Y / N Epilepsy
Y / N Cerebral Palsy
Y / N Tumor
Y / N Stroke/CVA; Year(s): _____
Y / N Migraine
Y / N Autism Spectrum Disorder
Y / N Other: _____

Psychiatric
Y / N Depression
Y / N Attention Deficit
Y / N Anxiety Disorder
Y / N Bipolar Disorder
Y / N Other: _____

Cardiovascular
Y / N Hypertension
Y / N Stroke/CVA
Y / N Heart Disease
Y / N Congestive heart failure
Y / N Other: _____

Respiratory
Y / N Cigarette smoker
Y / N Asthma
Y / N Bronchitis
Y / N Emphysema
Y / N Chronic obstructive sleep apnea
- CPAP use (or other device) Y / N
Y / N COPD
Y / N Other: _____

Gastrointestinal
Y / N Chron's
Y / N Colitis
Y / N Ulcer
Y / N Acid Reflux
Y / N Celiac Disease
Y / N Other: _____

Genito-urinary
Y / N Kidney Disease
Y / N Prostate Disease/cancer
Y / N STD – herpetic/chlamydia
Y / N Benign Prostate Hypertrophy
Y / N Pregnant (currently)
Y / N Nursing (currently)
Y / N Chlamydia
Y / N Other: _____

Musculoskeletal
Y / N Osteoarthritis
Y / N Arthritis
Y / N Fibromyalgia
Y / N Muscular Dystrophy
Y / N Ankylosing Spondylitis
Y / N Osteoporosis
Y / N Gout
Y / N Other: _____

Integumentary
Y / N Eczema
Y / N Rosacea
Y / N Psoriasis
Y / N Herpes Simplex/Cold Sores
Y / N Herpes Zoster/Shingles
Y / N Other: _____

Endocrine
Y / N Type 1 Diabetes Mellitus
- Year of Diagnosis _____
- Last A1C _____
Y / N Type 2 Diabetes Mellitus
- Year of Diagnosis _____
- Last A1C _____
Y / N Thyroid dysfunction
Y / N Hormonal dysfunction
Y / N Other: _____

Hematologic/Lymphatic
Y / N Anemia
Y / N Large volume blood loss
Y / N Ulcer
Y / N High Cholesterol
Y / N Other: _____

Allergic/Immune
Y / N Drug Allergies
Y / N Environmental allergies
Y / N Rheumatoid arthritis
Y / N Lupus
Y / N Sjogren's Syndrome
Y / N Other: _____

CONTINUED ON BACK

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Patient Ocular History

Y / N Glaucoma
Y / N Glaucoma Suspect
Y / N Cataract
Y / N Age-related Macular Degeneration
Y / N Surgery
- Please describe: _____
Y / N Patching
Y / N Inflammatory disorder
Y / N Strabismus
Y / N Amblyopia
Y / N Retinal Degeneration
Y / N Retinal Hole
Y / N Retinal Detachment
Y / N Keratoconus
Y / N Injury
- Please describe: _____
Y / N Dry eye
Y / N Nystagmus
Y / N Other: _____

Social History

Y / N Drug user
Y / N Alcohol use; Drinks per week: _____
Y / N Never Smoker
Y / N Heavy Smoker
Packs per week: _____
Y / N Light Smoker
Packs per week: _____
Y / N Former Smoker. Year Quit: _____

Major Surgeries

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Contact Lens History

□ Soft □ RGP/Hard lens □ Hybrid
Contact lens brand: _____
Contact Lens Rx
Right eye:
Left eye:
How many hours per day do you wear your contacts? _____
How often do you replace your contacts? □ Daily □ Every 2 Weeks □ Monthly □ Other:
Do you wear your contacts overnight? □ Yes □ No
What solution do you use to clean your contacts? _____

Family Medical History **Relationship**

Y / N Cancer _____
- Please describe:
Y / N Type 1 Diabetes Mellitus _____
Y / N Type 2 Diabetes Mellitus _____
Y / N Hyperthyroidism _____
Y / N Hypothyroidism _____
Y / N Hypertension _____
Y / N Other: _____ _____

Family Ocular History **Relationship**

Y / N Cataract _____
Y / N Degenerative disorder of macula _____
Y / N Glaucoma _____
Y / N Other: _____ _____

Primary Care Physician

Full Name _____ Address _____

Phone Number _____ City _____ State _____ Zip Code _____

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops, and dosages for each:

_____
_____
_____
_____
_____

Allergies to Medication □ No allergies to medications

List any allergies you might have and the associated reaction:

_____
_____

Other Allergies

List any allergies you might have and the associated reaction:

_____

Authorization & Release of Benefits

I hereby authorize direct payment of benefits to Chicopee Eyecare for services rendered by the providers. I authorize the release of any medical information that may be required in determination of such benefits. I understand that some services may require approval of my Primary Care Physician for coverage and that if I do not obtain that approval, I am financially liable for the services. I understand that I am financially responsible for any balances not covered by my insurance, including co-pays, deductibles, contact lens evaluation fees, refractions, diagnostic testing, and products such as glasses and contact lenses. I acknowledge that I viewed a copy of the Chicopee Eyecare "Notice of Privacy Act, HIPAA policy, and received one upon request."

Signature of Responsible Party _____ Date _____