Prairie Eyecare Center · PC

Dr. Jeffrey W. Sanger
Dr. Jincy A. Ross
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Broken Bow, NE 68822
(308)872-2291 Fax (308)872-3122

Date:_____

Patient's Name _____ Male __
Last First MI Nickname Female __

Date of Birth _____
Mailing Address _____
City_____ State _____ Zip_____
Preferred method of notification ____ Home ____Cell ____Email ____Work
Home Phone_____Cell Phone _____ Email_____
Last 4 of SSN#_____

If form is being completed for an adult, please complete the following information:

Occupation_____
Employer_____ Work Phone _____
Name of Spouse if married _____ Spouse's Occupation_____
Spouse's Employer_____ Spouse's Work Phone_____

If form is being completed for a dependent, please complete the following information:

If patient is a student: Grade or Year in School _____
Father's name _____Last 4 SSN_____
Address (if different from patient)_____
Occupation_____ Employer_____
Father's work phone_____Father's Cell Phone_____
Mother's Name_____Last 4 OF SSN_____
Address (if different from patient)_____
Occupation_____ Employer_____
Mother's work phone_____Mother's Cell Phone_____

Emergency Contact Person (Not living in your household)_____
Daytime Phone _____ Relationship_____
Have you or any member of your immediate family been a patient at Prairie EyeCare Center?
If yes, please name_____
To help our office keep more accurate records, please list any other family member living at home and their ages_____
How were you referred to our office? Friend or Relative (Please name)_____
__Internet __Newspaper __Yellow pages__Radio __Word of Mouth __ All About Vision __ Facebook __Other

Payment policy: Full payment is due at the time service is rendered.
We accept Cash, Check, Visa, Mastercard, Discover, and Care Credit.

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Patient's Name_____Last Eye Exam_____Last Medical Exam_____

Medical History

Name of Primary Medical Doctor

_____

Do you have any allergies to medications? If Yes, Please list and explain

_____

Circle **any of the following that you have had:** crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injuries.
Are you pregnant or nursing? ___Yes ___No
Do you wear glasses? ___Yes ___No If yes, how old is your present pair of glasses? _____
Do you currently wear sunglasses with ultraviolet protection? ___Yes ___No
Are you interested in Contact Lenses? ___Yes ___No
Do you wear contact lenses? ___Yes ___No If yes, how what type/brand of contact lenses are you wearing and how old is your current pair of contact lenses?_____
Are your contacts comfortable? ___Yes ___No
Type of contact lens __Rigid __Soft __Extended wear __Other

Social History:

To be compliant with Medicare and other Insurance companies, we are required to ask this information.
___ I would prefer to discuss my social history with the doctor.
Ethnicity_____ Race_____ Approximate Height____ Approximate Weight_____
Do you Drive? ___Yes ___No If yes do you have difficulties when driving? _____
Do you use tobacco products? ___Yes ___No ___Occasionally How much/often?_____
Do you use illegal drugs? ___Yes ___No ___ Occasionally How much/often? _____
Do you drink alcohol?___Yes ___No ___ Occasionally How much/often?_____
Have you ever been exposed to or infected with: __Gonorrhea __Hepatitis __HIV __Syphilis?

Academic History (For children 18 and under)

Indicate any of these symptoms when reading:
__Poor comprehension __Poor memory __Visual fatigue __Works slowly __Seems too hard
__Avoidance __Eye strain __Loses place __Can't stay on task __Headaches during or after reading
Is the child achieving at expected levels at school? ___Yes ___No

Please circle your current Visual or Eye Concerns:

Loss of Vision	Blurred Vision	Distorted Vision or Halos	Loss of side vision
Double Vision	Dryness	Mucous Discharge	Redness
Sandy or Gritty Feeling	Itching	Burning	Excessive Tearing or Watering
Glare or Light Sensitivity	Eye Pain/Soreness	Chronic Infection of Eye or Eyelid	Styes or Chalazion
Flashes or Floating spots	Tired Eyes	Headaches	Other

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Personal Ocular History: Please Indicate if you have had any of the following

Disease/Condition	Yes	No	?	Please describe any previous treatments
Glaucoma				
Cataracts				
Macular Degeneration (ARMD)				
Eye Injury				
Retinal Disease				
Other Disease				
Blindness				
Strabismus (Eye-Turning Lazy Eye)				
Amblyopia (Focusing Lazy Eye)				
Diabetes				
Dry Eyes				
Refractive (Need for Glasses)				
Other				

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	Yes	No	?	Relationship to You
Glaucoma				
Cataracts				
Macular Degeneration (ARMD)				
Eye Injury				
Retinal Disease				
Other Disease				
Blindness				
Strabismus (Eye-Turning Lazy Eye)				
Amblyopia (Focusing Lazy Eye)				
Diabetes				
Cancer				
Heart Disease				
Other				

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Medical History: Review of Systems

Please indicate if any of the following medical conditions apply to you.

Constitutional	Development disability Unintended Weight loss Persistent Fever Chronic Fatigue Trauma Other
Cardiovascular	Heart Disease High blood Pressure Stroke Vascular Disease Other
Ears/Nose/Throat/Mouth	Runny nose/Hay Fever Sinus Congestion Dry Mouth/Throat Cancer Other
Respiratory	Emphysema/Asthma Pneumonia Bronchitis/Cough Cancer Other
Gastrointestinal	Diarrhea Constipation Heartburn/Ulcer Cancer Other
Genitourinary	Genital/Prostrate Kidney/Bladder Ovary/Uterus/Vagina Cancer Other
Musculoskeletal	Muscle/Joint Pain Muscle Spasms Muscle Weakness Arthritis Muscle/Joint Swelling Other
Integumentary (Skin)	Eczema/Psoriasis Dermatitis Rosacea/Acne Cysts/Warts/Skin Ulcer Cancer Other
Neurological/ Nervous System	Seizures Multiple Sclerosis Headaches/Migraines Paralysis Other
Psychiatric/Mental	Depression Panic/Anxiety Disorders Mood Changes Psychoses Amnesia/Sleep Disorders Other
Endocrine	Diabetes Hormonal Dysfunction Cholesterol/Lipid Problems Hyperthyroidism Hypothyroidism Cancer Other
Hematological or Lymphatic Blood Disorders	Anemia Bleeding Problems Leukemia Cancer Other
Allergic/Immunologic	Allergies Rheumatoid Arthritis Lupus Autoimmune Disease Other
Surgical Procedure	Cataracts Tonsils Appendix Other
Other	