



Prairie Eyecare Center · PC

Dr. Jeffrey W. Sanger
Dr. Jincy A. Ross
408 South 8th Ave. PO Box 506
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.



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:

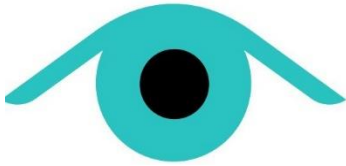
Poor comprehension Poor memory Visual fatigue Works slowly Seems too hard

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				



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	