PRIMARY FOCUS EYE CENTER

Dr. Shawn M. Kurtz, OD

Last Name:_____ First Name:_____ M:_____ DOB:___ / ___ / _____

Address:_____ City:_____ State:_____ Zip:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

M or F SSN:_____ / _____ / _____ Marital Status: Married / Single / Divorced / Widowed

Employer/School: _____ Occupation/School Grade: _____

Parent / Guardian_____ Phone #:_____

Email Address:_____ Today's Date:_____ / _____ / _____

Ocular History

Purpose of today's visit:

[ ] Annual Visit [ ] Headaches
[ ] Blurry Vision [ ] Infection
[ ] Burning [ ] Itchiness
[ ] Double Vision [ ] Night Vision Difficulty
[ ] Dryness [ ] Eye Pain
[ ] Flash of Light [ ] Tearing
[ ] Floaters/Spots [ ] Update Contact Lenses
[ ] Grittiness

When was your last eye exam?_____

Do you wear contact lenses? Y N

Have you been diagnosed with the following?

[ ] Cataracts [ ] Macular Degeneration
[ ] Corneal Abrasion [ ] Retinal Defect / Hole / Tear
[ ] Dry Eye [ ] Retinal Detachment
[ ] Eye Turn / Lazy Eye [ ] Other eye Diseases
[ ] Glaucoma [ ] None
[ ] Iritis / Uveitis

List Any Prior Eye Surgeries & Dates if Known (e.g. LASIK)

Has anyone in your **family** been diagnosed with the following?

[ ] Glaucoma [ ] Other Eye Diseases
[ ] Macular Degeneration [ ] None
[ ] Retinal Detachment

Are you Pregnant or Nursing? Y N
Do You Use Cigarettes? Y N If So, How Often?_____
Do You Drink Alcohol? Y N If So, How Often?_____

Visual Needs Assessment:

Hours of computer usage per day:_____
Hours of outdoor activity per day:_____
Hobbies:_____

How many hours do you read before you experience fatigue:_____
Circle if you have: Eye strain Neck Strain Headaches

INSURANCE INFORMATION

Medical Insurance:_____
Medical ID:_____ Group #_____
Policy Holder's Name If Different:_____
Policy Holder DOB _____ / _____ / _____
Relationship to Patient:_____

CIRCLE YOUR VISION INSURANCE

VSP Same as Medical Other None
Provider One ID:_____

Primary Physician / Clinic:_____

Last Medical exam: _____ / _____ / _____

Current Medications & Dose (Include OTC & Supplements)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: _____

Medical History

Have you ever been diagnosed or treated for any of the following Health Problems? (If yes include diagnosis; otherwise, circle N for No and F for family history)

Allergies	Y	_____	N	F
Arthritis	Y	_____	N	F
Blood/lymph	Y	_____	N	F
Cancer	Y	_____	N	F
Cholesterol	Y	_____	N	F
Diabetes	Y	**Type** _____	N	F
Digestive/Gastric	Y	_____	N	F
Ears/Nose/Throat	Y	_____	N	F
Endocrine	Y	_____	N	F
Fatigue	Y	_____	N	F
Fevers	Y	_____	N	F
Heart Disease	Y	_____	N	F
High Blood Pressure	Y	_____	N	F
Immune	Y	_____	N	F
Integumentary (Skin Disease)	Y	_____	N	F
Kidney	Y	_____	N	F
Muscle or Bone	Y	_____	N	F
Neurological/Headaches	Y	_____	N	F
Psychological	Y	_____	N	F
Respiratory	Y	_____	N	F
Sinus	Y	_____	N	F
Stroke/Seizures	Y	_____	N	F
Throat Infections	Y	_____	N	F
Thyroid	Y	_____	N	F
Unusual Weight Loss/Gain	Y	_____	N	F