Welcome to Cargill Eyecare Wexford

We Welcome New Patients and *Thank You For Your Referrals* !

Last Name ____________ First / M.I. ____________ D. O. B. ____________

Soc.Sec.# ____________ Med Ins ID # ____________ Group# ____________

Title: ( ) Miss ( ) Ms. ( ) Mrs. ( ) Mr. ( ) Dr. Married Y ( ) N ( ) Vision Insurance Plan ____________

Street Address ____________ ____________

City ____________ State ____________ Zip Code ____________

Home Phone ____________ Employer ____________

Work Phone ____________ Occupation ____________

Cell Phone ____________

E-MAIL ____________

Family Doctor / Office Location ____________

Current Medications ____________

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Referred By:

___ Family

___ Friend(name) ____________

___ Doctor

___ Yel. Page

___ Insurance Plan

Last Health Exam? ____________

Allergies to Medications (e.g. sulfa, penicillin)? ____________

Eyeglass/Contact Lens/ Lasik History

Does glare bother you in flourescent light or while driving at night? Y / N Date of Last Eye Exam? ____________

Have you ever worn contact lenses? Y / N Still wear them? Y / N If not, why not? ____________

Are you interested in wearing contact lenses? Y / N Please list unfavorable past experiences with glasses, contact lenses, or their solutions so that we may avoid repeating them: ____________

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Are you interested in laser vision correction? Y / N Have you already had Lasik? If so when?________________________

Family History

Do you (self) or any blood relative (r) living or deceased, have any of the following? Please circle.

self / rel	Glaucoma	self / rel	Rheumatoid Arthritis	self / rel	Epilepsy
self / rel	Cataract	self / rel	Lupus	self / rel	Eczema
self / rel	Retinal Detachment	self / rel	Asthma	self / rel	Rosacea
self / rel	Macular Degeneration	self / rel	Emphysema	self / rel	STD-viral, herpetic
self / rel	High Blood Pressure	self / rel	Ulcers	self / rel	Urinary problems
self / rel	Poor Circulation	self / rel	Gastric Reflux	self / rel	Fainting
self / rel	Stroke	self / rel	Chrohn's Disease	self / rel	Depression/Anxiety
self / rel	High Cholesterol	self / rel	Arthritis	self / rel	Anemia
self / rel	Diabetes	self / rel	Fibromyalgia	self / rel	Leukemia
self / rel	Thyroid	self / rel	Multiple Sclerosis		
self / rel	Seasonal Allergies	self / rel	Seizures		

Do you get headaches? Y / N Recent Onset? Y / N

What causes your headaches and what do you do for relief? ____________

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