MISSOURI
EYE CONSULTANTS
Ph 573-874-2030 • Fax 573-449-0253
MOeyes.com

Welcome to Our Practice

Appointment Date: _____ Appointment Time: _____

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____

City: _____ Zip: _____ Birth Date: _____ / _____ / _____

Email: _____ Social Security #: _____ / _____ / _____

Employer: _____ Occupation: _____

Guardian (If Applicable): _____ Last Eye Exam: _____ / _____ / _____

Medical Doctor: _____

Emergency contact: _____ Cell Phone: _____

How did you hear about our practice: ☐ Recommended by friend or family _____

☐ Your insurance Provider List ☐ Referral from your doctor _____

☐ Internet / Our website ☐ Phone book ☐ Other _____

We are providers for Medicare, Missouri Medicaid, Essence, Cigna, Blue Cross/Blue Shield, Vision Care Direct, UMR, United Healthcare, Coventry, Humana, Healthlink, VSP, EyeMed, Delta Vision, NVA, and Advantica. If you have other insurance, we will provide you with an itemized receipt on the day of your examination that you may file with your insurance company. If you do not have one of the plans we accept, payment is requested on the day services are rendered.

Insurance Carrier: _____(the staff will need to make a copy of your insurance card)

MEDICAL HISTORY

List the medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Do you have any allergies to medications? ☐ no ☐ yes If yes, explain: _____

_____

List all major surgeries, injuries and/or hospitalizations you have had: _____

_____

Circle any of the following that you have had: crossed eyes lazy eye glaucoma retinal disease cataracts

eye infections eye injury eye surgery

Are you pregnant and/or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old are you current lenses? _____

Do you wear contact lenses? ☐ no ☐ yes

If yes, are they: ☐ soft disposable ☐ Rigid gas permeable ☐ Hybrid ☐ Other

Have you had vision surgery? ☐ no ☐ yes If yes, which? LASIK PRK RK Lens implants OTHER

* Please complete the next page

SOCIAL HISTORY

This information is kept strictly confidential. If you prefer, you may discuss directly with your doctor.

Do you use tobacco products? ☐ no ☐ yes If yes, type / amount / how long: _____

Do you drink alcohol? ☐ no ☐ yes If yes, type / amount / how long: _____

Do you use illegal drugs? ☐ no ☐ yes If yes, type / amount / how long: _____

FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Loss of Peripheral Vision	☐	☐	☐
Double Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Red Eyes	☐	☐	☐
Itching	☐	☐	☐
Glare / Halos / Light Sensitivity	☐	☐	☐
Chronic Eye Infections	☐	☐	☐
Flashes / Floaters	☐	☐	☐
Computer Eye Strain	☐	☐	☐
Dry Eyes	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Dry Mouth / Throat	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
CARDIOVASCULAR			
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTIONAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder	☐	☐	☐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle / Joint Pain	☐	☐	☐
LYMPHATIC			
Anemia / Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PYSCHIATRIC	☐	☐	☐

If you answered yes to any of the above or have a condition not listed, please explain:

_____

_____