TODD F. BIRCH, OD
JARED E. BIRCH, OD

SUMMIT EYECARE

CRAIG A. FLEMIING, OD
JAY L. BORGHOLTHAUS, OD

PATIENT INFORMATION

Today's Date:_____
Last Name:_____
First Name:_____ MI:_____
Date of Birth:_____ Gender:_____
Race:_____
Ethnicity:_____
Patient's SSN:_____
Address:_____
City:_____ State:_____
ZIP Code:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
E-mail Address:_____
Employer:_____
Occupation:_____
Spouse's (or Parent's) Name:_____
Spouse's (or Parent's) Occupation:_____

FOR NEW PATIENTS ONLY

Who or what led you to choose our office for your vision care needs? _____

_____

INSURANCE INFORMATION

You are responsible for providing current, accurate insurance information in order for your insurance claim to be filed. We are happy to assist you in understanding your benefits.

Vision Insurance:_____
Subscriber Name:_____
Subscriber ID:_____
Subscriber DOB:_____
Medical Insurance:_____
Subscriber Name:_____
Subscriber ID:_____
Subscriber DOB:_____
Secondary Insurance:_____
Subscriber Name:_____
Subscriber ID:_____
Subscriber DOB:_____

The information you provide on this history form is critical to the evaluation of your vision and health. Complete both sides with total accuracy.

LIFESTYLE QUESTIONS

What is your preferred language?_____
What is the best way to contact you?_____

Do you…
☐ Work at a computer? How much? _____
☐ Have an interest in thinner, lighter lenses?
☐ Spend time outdoors? How much? _____
☐ Have sunglasses?
☐ Prefer to not wear your glasses?
☐ Want information about LASIK?
☐ Have more than one pair of prescription glasses?
☐ Have children?
☐ Have family members in need of eyecare?

Date of Last Eye Exam:_____
Name of Doctor:_____
Do you wear…? ☐ Glasses ☐ Contact Lenses
If yes, what type? _____
Solution used:_____

PATIENT SOCIAL HISTORY

☐ Check this box if you prefer to discuss this portion directly with the doctor.

Do you (please list frequency and type)…
☐ Drive? _____
☐ Use tobacco products? _____
☐ Drink alcohol? _____
☐ Use recreational drugs? _____

PATIENT EYE HISTORY

Have you experienced, been diagnosed with, or been treated for any of the following?

☐ Blurred Vision	☐ Burning
☐ Cataract	☐ Corneal Abrasion
☐ Lazy Eye	☐ Double Vision
☐ Eye Infections	☐ Eye Injury
☐ Light Flashes	☐ Floaters/Spots
☐ Glaucoma	☐ Grittiness
☐ Headache	☐ Iritis/Uveitis
☐ Itchiness	☐ Macular Degeneration
☐ Dry eye	☐ Retinal Detachment
☐ Tearing	☐ Poor Night Vision
☐ Vision Loss	☐ Eye Fatigue
☐ Discharge	☐ Foreign Body Sensation
☐ Stye or Chalazion	☐ Distortion/Halos
☐ Light Sensitivity	☐ Redness

☐ Other eye disorder:_____

PATIENT MEDICAL HISTORY

Primary Care Provider:_____
Location:_____
Date of Last Physical:_____

CURRENT MEDICATIONS (please list all prescription or over-the-counter medications you use, including eye drops, vitamins, and birth control):_____

ALLERGIES (including seasonal and medication allergies):_____

Have you experienced, been diagnosed with, or been treated for any of the following?

☐ Allergies	☐ Endocrine Disorder	☐ Constipation	☐ Multiple Sclerosis
☐ Cardiovascular Disease	☐ Crohn's Disease	☐ Genitourinary Disorder	☐ Brain Damage
☐ High Blood Pressure	☐ Thyroid Disorder	☐ Blood Disorder	☐ Epilepsy
☐ High Cholesterol	☐ Diabetes	☐ Anemia	☐ Psychiatric Disorder
☐ Stroke	☐ Hypoglycemia	☐ Skin Disorder	☐ Attention Disorder
☐ Heart Arrythmia	☐ Pituitary Disorder	☐ Rosacea	☐ Depression
☐ Constitutional Disorder	☐ Renal Disease	☐ Eczema	☐ Autism
☐ Fever	☐ Gout	☐ Musculoskeletal Disorder	☐ Dementia
☐ Chills	☐ Gastrointestinal Disease	☐ Arthritis	☐ Respiratory Disorder
☐ Weight Loss/Gain	☐ Nausea	☐ Muscle/Joint Pain	☐ Asthma
☐ Fatigue	☐ Vomiting	☐ Neurological Disorder	☐ Bronchitis
☐ Cancer	☐ Diarrhea	☐ Headache	☐ COPD/Emphysema

Use the space below to explain any condition marked above or any unlisted conditions that you may have:

_____
_____
_____
_____

SURGERIES (please list all systemic and ocular surgeries you have had):_____

FAMILY MEDICAL/EYE HISTORY

Does a history of any of the following conditions exist in your family (please list relationship)?

☐ Blindness_____	☐ Diabetes_____
☐ Cataracts_____	☐ Heart Disease_____
☐ Corneal Problems_____	☐ High Blood Pressure_____
☐ Glaucoma_____	☐ Kidney Disease_____
☐ Lazy Eye_____	☐ Lupus_____
☐ Macular Degeneration_____	☐ Thyroid Disease_____
☐ Retinal Problems_____	☐ Cancer_____
☐ Other:_____	☐ Arthritis_____

I affirm that the information I have provided on this patient history form is accurate to the best of my knowledge.

Signature:_____ Date:_____