



# Welcome Back To Our Office

## PATIENT HISTORY

Today's Date \_\_\_\_\_  
 Last \_\_\_\_\_  
 First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Marital Status Married \_\_\_ Single \_\_\_ Divorced \_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex M F  
 Email Address \_\_\_\_\_  
 What is the major purpose of this visit? \_\_\_\_\_  
 \_\_\_\_\_  
 Any problems with your current contact lenses or glasses?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## THE OFFICE OF DR GREGORY R. BARCUS

### OUR MISSION

*Our eye care team provides high quality care,  
 with a personal touch, for the best quality of life.*

## INSURANCE INFORMATION

*Please note that insurance does NOT cover  
 the Contact Lens Follow-Up Evaluation.*

Vision Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_  
 Primary Medical Insurance \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_  
 Do you participate in a flex spending account?  
 Yes  No  
 How will you settle your account today?  
 Cash  Check  Credit Card

## LIFESTYLE QUESTIONS

### Do you (check box if your answer is yes)

- work at a computer? If yes, please complete computer questionnaire.
- think you might benefit from thinner, lighter lenses?
- have interest in a "test drive" of the latest contact lens designs
- spend time outdoors? How much? \_\_\_\_\_ Hrs/week
- have prescription sunwear?
- prefer not to wear your glasses at times?
- want information on Laser Vision Correction surgery
- have more than 1 pair of current Rx eyewear?
- have children?
- have family members in need of eyecare?

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

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision               | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn        | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections              | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light              | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                   | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchiness                   | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration        | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment          | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing                     | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses       |  |
| <input type="checkbox"/> Other eye disorder(s) _____ |  |

The information in this confidential case history form is critical to the evaluation of your vision and health.

### PATIENT MEDICAL HISTORY

Name of Family Physician \_\_\_\_\_

Town \_\_\_\_\_

Date of Last Physical Check-up \_\_\_\_\_

#### CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) \_\_\_\_\_

Allergies to medications? Yes No

If so, what medications? \_\_\_\_\_

Have you had any surgeries? Yes No

Do you use cigarettes/tobacco, alcohol, or other substances? Yes No

#### Have you ever been diagnosed or treated for the following health problems? Yes No

Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary(Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

**DR. GREGORY R. BARCUS**  
**WE ARE HIPPA COMPLIANT!**

### PATIENT EYE HISTORY

Date of Last Eye Exam \_\_\_\_\_

By Whom? \_\_\_\_\_

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No

What kind? \_\_\_\_\_

Solutions used \_\_\_\_\_

Are you satisfied with the vision and comfort of your contact lenses? Yes No

Would you prefer clear contact lenses or colored contact lenses? Clear Colored

If you wear bifocals, do the lines or head tilting bother you? Yes No

### FAMILY MEDICAL/EYE HISTORY

(CHECK ALL THAT APPLY)

Is there a family medical history of any of the following:  
(Please check boxes) Relationship (Mother's or Father's side)

Blindness Yes No \_\_\_\_\_

Cataracts Yes No \_\_\_\_\_

Corneal Problems Yes No \_\_\_\_\_

Diabetes Yes No \_\_\_\_\_

Glaucoma Yes No \_\_\_\_\_

Heart Disease Yes No \_\_\_\_\_

Lazy Eye Yes No \_\_\_\_\_

Macular Degeneration Yes No \_\_\_\_\_

Retinal Problems Yes No \_\_\_\_\_

### PLEASE BE ADVISED:

If you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Dr. Barcus's office.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

PLEASE ENTER YOUR CREDIT CARD NUMBER AND EXPIRATION DATE.

CC#: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_

SIGNATURE \_\_\_\_\_