Dr. Mamie Chan
ABQ Eye Care

DATE: ____________________ Whom may we thank for referring you? ____________________

Have you seen Dr. Chan before? Yes No If So Where? ____________________

WE SEND MESSAGE ALERTS VIA TEXT AND/OR EMAIL. Text ok ☐ EMAIL ____________________

Info given to ABQ Eye Care is used for in Office use only. Used for notifications on appointments, eye glasses, contacts, promotions, ect.

INSURANCE INFORMATION

Insurance Name ____________________ Policy Holders Name and DOB ____________________

Policy Holders Insurance ID # ____________________ Relation to Insured ____________________

PATIENT INFORMATION

First Name ____________________ MI ________ Last Name ____________________

Address ____________________ Apt# ________ City ____________________ State ________ Zip ____________

Date of Birth ____________________ Age ________ Social Sec# ________-________-__________ Sex: ☐ Male ☐ Female

Day Phone (_____) ______-_______ Cell Phone (_____) ______-_______ **Ok to receive Text Messages YES or NO**

Occupation ____________________ Employer ____________________ ☐ Full Time ☐ Part Time

Hobbies: ____________________

Are you: ☐ A Minor ☐ Single ☐ Married ☐ Divorced ☐ Other

Emergency contact Name & Number ____________________

If you are a minor: Guardian's Name and Contact Information: ____________________

MEDICAL INFORMATION

Date of last Medical Examination ____________________ Name of Family Doctor ____________________

Do you currently use: ☐ cigarettes/tobacco ☐ alcohol ☐ other substances ☐ none

Please check if you or a blood relative have been diagnosed with a problem with any of the following:

☐ Allergies
☐ Arthritis
☐ Blood/Lymph
☐ Cancer
☐ Cardiovascular
☐ Constitutional
☐ Diabetes
☐ Ears/Nose/Throat
☐ Endocrine (glands)
☐ Eyes
☐ Gastrointestinal
☐ Genitourinary
☐ Gout
☐ Heart Disease
☐ Hematologic
☐ High Blood Pressure
☐ High Cholesterol
☐ Immunologic
☐ Infectious
☐ Integumentary (skin)
☐ Kidney / Liver Disease
☐ Lupus
☐ Musculoskeletal
☐ Nervous
☐ Neurological
☐ Psychiatric
☐ Respiratory
☐ Currently Pregnant / Nursing
☐ Sjogren's Syndrome
☐ Thyroid Disorder
☐ Tuberculosis
☐ Other ____________________

Please explain if you checked any of the above ____________________

Current Medication(s): ____________________ Medication Allergies: ____________________

☐ None ____________________ ☐ None ____________________

EYE INFORMATION

When was your last eye exam? ____________________ Which Dr. did you see? ____________________

Do you wear glasses? ☐ No ☐ Yes If yes, how long? ____________________ How old is your current pair? ____________________

Do you wear contact lenses? ☐ No ☐ Yes If yes, how long? ____________________ What kind / type? ____________________

Have you had any eye operations? ☐ No ☐ Yes If yes, what kind? ____________________ Date ____________________

Have you had any eye injury? ☐ No ☐ Yes If yes, what kind? ____________________ Date ____________________

Please check if you or a blood relative has been diagnosed with any of the following:

☐ Amblyopia / Lazy eye
☐ Cataract
☐ Color Vision Defect
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Retinitis Pigmentosa
☐ Strabismus / Eye Turn
☐ Other ____________________

Please explain if you checked any of the above ____________________

Please check if you are currently experiencing any of the following eye symptoms:

☐ Blurry Vision at Distance
☐ Blurry Vision at Near
☐ Burning
☐ Eye Pain or Soreness
☐ Eyestrain
☐ Flashes of Light or Floaters
☐ Foreign Body Sensation
☐ Headaches
☐ Infection of Eye or Eyelid
☐ Itching
☐ Light Sensitivity
☐ Dry Eye
☐ Mucous Discharge
☐ Red eyes
☐ Watering Eyes
☐ Other ____________________

Guardian or Patient Signature ____________________ Doctor's Initials: ____________________

Relationship to Patient: ____________________