INSIGHT EYECARE Dr. Michelle Higgins, O.D.
26 School Street Yarmouth, ME 04096 Ph: 207 847-3800 Fax: 207 847-3802

Welcome to our office. Thank you for choosing us for your eye care.

Please PRINT - *ALL INFORMATION IS KEPT CONFIDENTIAL* – **Please PRINT**

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

Mailing Address:_____ Phone:_____

City: _____ Zip: _____ Work Phone: _____

Email _____ Preferred Contact Method: □ Email or □ Phone

How did you hear about us? □ Web Page □ Newspaper □ Referred □ Other _____

Guardian (If Applicable):_____ Your Occupation: _____

Birth Date: ___ /___ /____ Social Security #:___ /__ /____ Last Eye Exam: ___ /___ /_____

Name of Medical Doctor: _____ Last Medical Exam: ___ /___ /____

Medical History: Are you pregnant and/or nursing? □ no □ yes

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

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies). If you have a list, we would be happy to make a copy:
_____
_____

Check ALL of the following you have had:

Crossed eyes/lazy eye/patched	□	Cataracts	□
Eye Surgery	□	Eye infections or eye injury	□
Loss of Vision	□	Contact lens intolerance	□
Double Vision	□	Mucous Discharge	□
Blurred Vision	□	Foreign Body Sensation	□
Loss of Side Vision	□	Excess Tearing/Watering	□
Red Eyes/ Infections	□	Glare/Light Sensitivity	□
Floaters	□	Eye Pain or Soreness	□
Glaucoma	□	Sties or Chalazion	□
Retinal disease	□	Tired Eyes	□

Do you wear glasses? □ no □ yes If yes, how old is your present pair of lenses?_____

Do you wear contact lenses? □ no □ yes If yes, how old is your pair of contacts? _____
Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other _____
Are they comfortable? □ no □ yes

Family History: Please check any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions. If unsure, add a "?".

Disease/Condition	Relationship to You	Disease/Condition	Relationship to You
Blindness □	_____	Diabetes □	_____
Cataract □	_____	Heart Disease □	_____
Crossed Eyes □	_____	High Blood Pressure □	_____
Glaucoma □	_____	Kidney Disease □	_____
Macular Degeneration □	_____	Lupus □	_____
Retinal Detachment/Disease □	_____	Thyroid Disease □	_____
Arthritis □	_____	Others □	_____
Cancer □	_____		_____

Social History: *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. If so, please check the following box.*

□ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? □ no □ yes If yes, do you have visual difficulty when driving?
□ no □ yes If yes, please describe: _____

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: _____

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

SYSTEM	YES
CONSTITUTIONAL	
Fatigue Syndrome	□
Developmental Disabilities	□
Cancer	□
EARS, NOSE, MOUTH, THROAT	
Laryngitis	□
Sinusitis	□
Dry Mouth	□
Hearing Loss	□
NEUROLOGICAL	
Cerebral Palsy	□
Epilepsy	□
Tumor	□
Multiple Sclerosis	□
PSYCHIATRIC - Depression	□
CARDIOVASCULAR	
Congestive Heart Failure	□
Hypertension	□
Heart Disease	□
Vascular Disease	□
Stroke	□

	YES
RESPIRATORY	
Asthma	□
Emphysema	□
Cigarette Smoker	□
Bronchitis	□
Chronic Obstruction	□
GASTROINTESTINAL (GI)	
Chron's	□
Ulcer	□
Colitis	□
GENITOURINARY (GU)	
STD-Herpetic/Chlamydia	□
Kidney Disease	□
Prostate Disease/Cancer	□
MUSCULOSKELETAL	
Fibromyalgia	□
Ankylosing Spondylitis	□
Muscular Dystrophy	□
Osteoarthritis	□

	YES
INTEGUMENTARY	
Eczema	□
Rosacea	□
Psoriasis	□
ENDOCRINE	
Thyroid Dysfunction	□
Non-insulin Dependent Diabetes	□
Hormonal Dysfunction	□
Insulin Dependent Diabetes	□
HEMOTOLOGIC/LYMPHATIC	
Anemia	□
Large Volume Blood Loss	□
Hypercholesteremia	□
ALLERGIC / IMMUNOLOGIC	
Environmental Allergies	□
Lupus	□
Rheumatoid Arthritis	□
Drug Allergies	□