Dr. Chad Nixon, O.D.
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www.eye-careone.com

Welcome to our office. The following information will assist your doctor with examination.
(If you need help completing this form, please ask for assistance.)

Last Name_____ First Name_____ MI_____ Date_____
Address_____ City_____ State_____ Zip Code_____
Telephone (C)_____ Email_____
Insurance ID #_____ Date of Birth_____
Occupation_____ Insurance Type _____
Employer_____ Insured's Name_____ Last 4 SSN_____ DOB_____
Emergency Contact Name & Telephone #_____
Date of Last Exam_____ Dilated? Yes/No

MEDICAL INFORMATION

What is your general health?_____
Do you have problems with any of these symptoms/ (Please circle all that apply)

Eyes	Yes/No	Nervous	Yes/No	Endocrine (glands) Blood/lymph	Yes/No
Gastrointestinal	Yes/No	Genitourinary	Yes/No	Allergic/immunologic	Yes/No
Ears/Nose/Throat	Yes/No	Musculoskeletal	Yes/No		
Cardiovascular	Yes/No	Integumentary (skin)	Yes/No		
Respiratory	Yes/No	Mental	Yes/No		

Please Explain_____

Please Answer all that apply:
Diabetes Yes/No Type_____ Date of Diagnosis_____
Allergies Yes/No Allergic to what?_____ What happens?_____
Allergy Medication Yes/No What?_____ Headaches? Yes/No
Other health Problems_____
Current Medications_____
Have you had any Operations? Yes/No
What Kind & When?_____
Do you use cigarettes/tobacco? Yes/No Alcohol? Yes/No Other Substance(s)?_____
Name of Family Doctor_____ Doctors Office_____ Date of Last Visit_____
Date of Last Tetanus Shot_____

FAMILY HISTORY

High Blood Pressure Yes/No Relation_____ Macular degeneration Yes/No Relation_____
Diabetes Yes/No Relation_____ Retinal detachment Yes/No Relation_____
Glaucoma Yes/No Relation_____ Cataracts Yes/No Relation_____
Other eye conditions? Yes/No What kind?_____ Relation_____

PERSONAL INFORMATION

Have you had an eye operation? Yes/No Type_____ Date_____
Have you had an eye injury? Yes/No Kind_____ Date_____
Do you have glaucoma? Yes/No Cataracts? Yes/No Dry Eyes? Yes/No Blurred Vision? Yes/No
Other Eye Problems? Yes/No What kind?_____
Do you wear glasses? Yes/No Contact Lenses? Yes/No Type/Brand_____
Additional information_____
Whom may we thank for referring you?_____