

**WELCOME TO THE OFFICE OF DR. BOWERS**

Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_  
Last Medical Exam: \_\_\_/\_\_\_/\_\_\_ Last Eye Exam: \_\_\_/\_\_\_/\_\_\_ Sex: M \_\_\_ F \_\_\_  
Insurance: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_  
Policy Holder's Name & SS#: \_\_\_\_\_

**WELCOME TO OUR OFFICE**

We are pleased that you have selected our office for your eye care. We pride ourselves in providing only the best care available for you and your entire family. Our number one goal is the continued health of your eyes and your complete satisfaction. We provide only the highest quality and most technologically advanced optical materials available today. Dr. Bowers believes in total family eye care and sees patients from infants to senior adults. Dr. Bowers has an excellent working relationship with some of the best retinal and cataract surgeons in Northeast Tennessee which allows Blountville Family Eyecare to provide complete one stop eye care.

**FAMILY INFORMATION**

Please list family members that are part of your household. Many children fall behind in school simply because that can't clearly see either their board work or textbooks. Due to the rapid development of children, Dr. Bowers recommends that children be examined on a yearly basis to ensure normal eye development and optimal school performance. \_\_\_\_\_

How did you become aware of our practice?  Yellow Pages  Insurance Company  Radio Adv.  Referral from friend or family If referred by a friend or family member please provide their name so we may thank him/her for the kind referral. \_\_\_\_\_

**Social History**

Please indicate hobbies and interests:  Computers  Hunting  Fishing  Music  Public Speaking  Golfing  
Do you drive?  Yes  No  
Do you use tobacco products?  Yes  No If yes type/amount/how long: \_\_\_\_\_  
Do you drink alcohol?  Yes  No If yes type/amount/how long: \_\_\_\_\_  
Do you use illegal drugs?  Yes  No If yes type/amount/how long: \_\_\_\_\_  
Please indicate if you have been exposed or infected with:  Gonorrhea  Syphilis  HIV  Hepatitis  
Are you pregnant or nursing?  Yes  No

**Family History**

Please note any family history (parents, grandparents, siblings, children living or deceased) for the following:

Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease/Detachment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes which relatives? \_\_\_\_\_

**INSURANCE AND PAYMENT POLICIES**

Our office will, for your convenience, file your insurance. We will need to keep your signature on file to process your claims.

Payment for services is needed at the time of your visit. Payment of half is due to order your custom glasses or contacts, and the balance is due upon pick up. After ninety days in default of payment, you agree to pay the collection fees as permitted by state law.

\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Medical History**

Do you have any allergies to medications? \_\_\_ Yes \_\_\_ No If yes, please explain: \_\_\_\_\_

List any medication you take including over the counter medications: \_\_\_\_\_

List all major injuries and surgeries/hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, eye surgery, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, or eye injuries: \_\_\_\_\_

**Review of Systems**

Do you currently or have you ever had any problems in the following areas:

**Eyes**

- Loss of vision                    \_\_\_ Yes \_\_\_ No
- Blurred Vision                    \_\_\_ Yes \_\_\_ No
- Distorted Vision                    \_\_\_ Yes \_\_\_ No
- Loss of Side Vision                    \_\_\_ Yes \_\_\_ No
- Double Vision                    \_\_\_ Yes \_\_\_ No
- Dryness                    \_\_\_ Yes \_\_\_ No
- Mucous Discharge                    \_\_\_ Yes \_\_\_ No
- Redness                    \_\_\_ Yes \_\_\_ No
- Sandy/Gritty Feeling                    \_\_\_ Yes \_\_\_ No
- Itching                    \_\_\_ Yes \_\_\_ No
- Burning                    \_\_\_ Yes \_\_\_ No
- Foreign Body Sensation                    \_\_\_ Yes \_\_\_ No
- Excess Tearing/Watering                    \_\_\_ Yes \_\_\_ No
- Glare/Light Sensitivity                    \_\_\_ Yes \_\_\_ No
- Eye Pain or Soreness                    \_\_\_ Yes \_\_\_ No
- Infection                    \_\_\_ Yes \_\_\_ No
- Sties                    \_\_\_ Yes \_\_\_ No
- Flashes/Floaters                    \_\_\_ Yes \_\_\_ No
- Tired Eyes                    \_\_\_ Yes \_\_\_ No

**Ear, Nose, Mouth, and Throat**

- Allergies                    \_\_\_ Yes \_\_\_ No
- Hay Fever                    \_\_\_ Yes \_\_\_ No
- Sinus Congestion                    \_\_\_ Yes \_\_\_ No
- Runny Nose                    \_\_\_ Yes \_\_\_ No
- Chronic Cough                    \_\_\_ Yes \_\_\_ No
- Dry Throat/Mouth                    \_\_\_ Yes \_\_\_ No

**Vascular**

- Diabetes                    \_\_\_ Yes \_\_\_ No
- Heart Pain                    \_\_\_ Yes \_\_\_ No
- High Blood Pressure                    \_\_\_ Yes \_\_\_ No
- Vascular Disease                    \_\_\_ Yes \_\_\_ No

**Respiratory**

- Asthma                    \_\_\_ Yes \_\_\_ No
- Chronic Bronchitis                    \_\_\_ Yes \_\_\_ No
- Emphysema                    \_\_\_ Yes \_\_\_ No

**Gastrointestinal**

- Diarrhea                    \_\_\_ Yes \_\_\_ No
- Constipation                    \_\_\_ Yes \_\_\_ No

**Genitourinary**

- \_\_\_ Yes \_\_\_ No

**Bone/Joints/Muscle**

- Rheumatoid Arthritis                    \_\_\_ Yes \_\_\_ No
- Muscle Pain                    \_\_\_ Yes \_\_\_ No

**Lymphatic System**

- Anemia                    \_\_\_ Yes \_\_\_ No
- Bleeding Problems                    \_\_\_ Yes \_\_\_ No

**Endocrine(thyroid)**

- \_\_\_ Yes \_\_\_ No

**Psychiatric**

- \_\_\_ Yes \_\_\_ No

**Integumentary (Skin)**

- \_\_\_ Yes \_\_\_ No

**Neurological**

- Headaches                    \_\_\_ Yes \_\_\_ No
- Migraines                    \_\_\_ Yes \_\_\_ No
- Seizures                    \_\_\_ Yes \_\_\_ No

**Explanation:** \_\_\_\_\_

**Doctor's Use:** \_\_\_\_\_