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Our vision is to protect yours

Date: ____ / ____ / ____

Name: Last _____ First _____ M.I. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Mobile Phone: _____ Texting Okay? Y / N Work Phone: _____

Date of Birth: ____ / ____ / ____ Age _____ Male / Female SS#: _____

Marital Status: Single Married Other _____ Race: Asian / Black / Hispanic / White / Other _____

Employer: _____ Occupation: _____ Email: _____

How were you referred to our office? _____

Who is the insurance policy holder?

Self Other: Insured's Name: _____ Insured's DOB: ____ / ____ / ____

Insured's SSN: _____ Relationship to patient: _____

Name of Primary **Medical** Insurance Carrier: _____ ID # _____

Name of Secondary **Medical** Insurance Carrier: _____ ID # _____

Name of **Vision** Insurance Carrier: _____ ID # _____

~ You will be responsible for any portion of your bill which is not paid for by your insurance company.~

Eye History

Why did you schedule your visit today? _____

Do you wear glasses? Yes / No / Full-time / Part-time / Distance Only / Near Only

Do you currently wear contacts? Yes / No / Clear / Color Brand _____

Do you want to be fitted for contacts today? Yes / No / Clear / Color

Please check any of the following that apply

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Blurry Distance Vision | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Blurry Near Vision | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Wandering Eye | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Eye Infection | <input type="checkbox"/> Mucous Discharge | <input type="checkbox"/> Light Sensitive | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> Eye Pain / Soreness | <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Sandy/Gritty Feeling | <input type="checkbox"/> Prosthetic Eye |
| <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> See Flashes | <input type="checkbox"/> Poor Color Vision | |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> See Halos | <input type="checkbox"/> Droopy Lid | <input type="checkbox"/> None |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Glare or Reflection | |

Please complete other side

Patient Name: _____

Date: ____ / ____ / ____

Date of Last Eye Exam: _____ Where did you get your last exam? _____

Date of Last Physical/Medical Exam: _____ Name of Medical doctor: _____

Personal Medical History (Review of Systems)

Please check if any of the following applies to you.

Cardiovascular: None

- Hypertension
- Stroke
- Heart Disease
- Vascular Disease
- Other _____

Endocrine: None

- Non-Insulin Dependent Diabetes
- Insulin Dependent Diabetes
- Thyroid Problem
- Hormonal Dysfunction
- Other _____

Respiratory: None

- Asthma
- Bronchitis
- Emphysema
- COPD
- Other _____

Constitutional: None

- Weight loss/gain
- Fatigue
- Blackouts
- Other _____

Psychiatric: None

- ADHD
- Depression
- Schizophrenia
- Other _____

Ear/Nose/Throat: None

- Hearing Loss
- Upper Respiratory Infection
- Sinus Infection
- Other _____

Neurological: None

- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Other _____

Musculoskeletal: None

- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Other _____

Immunologic: None

- AIDS or HIV
- Rheumatoid Arthritis
- Lupus
- Neurofibromatosis
- Other _____

Hematological: None

- Anemia
- Leukemia
- Sickle Cell Disease
- Other _____

Gastrointestinal: None

- Chron's
- Colitis
- Acid Reflux
- Other _____

Dermatologic: None

- Eczema
- Rosacea
- Psoriasis
- Other _____

Genitourinary: None

- Bladder Infections
- Sexually Transmitted Disease
- Other _____

Tobacco Products: Never Smoked

- Former Smoker
- Current daily smoker
- Current occasional smoker

Alcohol Use: None

- Social Use
- Daily Use
- Dependency

Medication Allergies: _____ Other Allergies: _____

Please list all medications currently taken: _____

Please list any major surgeries: _____

Current Height: _____ Current Weight: _____

Family History

Disease/Condition	Relationship	Disease/Condition	Relationship
Glaucoma:	Yes/No _____	High Blood Pressure:	Yes/No _____
Macular Degeneration:	Yes/No _____	Diabetes:	Yes/No _____
Retinal Detachment:	Yes/No _____	Cancer:	Yes/No _____
Blindness:	Yes/No _____	Heart Disease:	Yes/No _____
Crossed Eyes:	Yes/No _____	Thyroid Disease:	Yes/No _____

